

Bundle Audit, Risk and Assurance Committee (Open) 24 June 2025

Agenda attachments

- 00 Agenda
- 0 OPENING ITEMS
- 1 09:45 – Chair's Welcome, Apologies and Quorum
- 2 Declarations of Interest
 - Board Member Register of Interests – Updated 26 March 2025
- 3 Minutes of the Last Open Meeting 1 May 2025
 - 2025-05-01 Draft ARAC OPEN Minutes
- 4 Action Log and Matters Arising
 - Action log open
 - Impact Assessments v2 240225 2
 - Highlight Report ARAC 1 May 2025
- 4.3 FOR APPROVAL, ASSURANCE AND DISCUSSION
- 5.1 09:50 – Annual Head of Internal Audit Opinion 2024/25
 - WAST_Fin05.2 WAST_ Final HOIA Opinion and Annual Report_2024-25 v1_for Trust issue
- 5.2 Internal Audit Reports
 - 5.2.1 Follow Up Audit on 2024/25*
 - 5.2.2 Contract Management*
 - 5.2.3 Seasonal Modelling and Forecasting*
 - 5.2.4 Start of Shift Procedure*
 - 5.2.5 Emergency Nurse Communications System Implementation*
 - 5.2.6 Capital Systems*
 - 5.2.1 WAS-2425-02_Follow Up_Final Internal Audit Report
 - 5.2.2 Contract Management Internal Audit
 - 5.2.2 Appendix 1 WAST-2425-03-Contract Management_Final Advisory Report
 - 5.2.3 WAS-2425-06 Forecasting & Modelling_Final Internal Audit Report
 - 5.2.4 WAS-2425-11 Start of Shift Procedure_Final Internal Audit Report
 - 5.2.5 WAS-2425-12 ECNS Final Internal Audit Report_for Trust issue
 - 5.2.6 WAS-SSU-2425-19 Capital Systems_Final Internal Audit Report
- 6.1 10:50 – Audit Wales Update Report
 - WAST Audit Committee Update 24062025
- 6.2 Urgent and Emergency Care Review
 - Urgent and Emergency Care Review
- 6.3 11:20 – COMFORT BREAK
- 7 11:35 – Risk Management Report
 - Executive Summary Risk Management Report ARAC 240625
 - Board Assurance Framework Extract Risk 223
 - Trending Data Assurance Committee March 2023-25
 - Trending Data Risk 163
 - Trending Data Risk List
- 8 11:50 – Audit Tracker
 - The Audit Tracker annexes are available in the Reading Room.*
 - Item 08 SBAR Audit Tracker to Committees – 2425 Q4 Reporting (January-March 2025) – For ARAC 240625 (Open Session) (1)
- 9 12:10 – Losses and Special Payments
 - Executive Summary SBAR Losses and Special Payments
 - Annex 1 – Losses Special and Payments 2024-25
 - Annex 2 – Losses Special and Payments 2025-26
- 10 12:20 – NHS Wales No PO No Pay Policy
 - ARAC SBAR – No Po No Pay
 - Annex 1 NHS-Wales-No-PO-No-Pay--No-Purchase-Order-No-Payment--Policy
- 11 12:30 – Integrated Governance Programme
 - Integrated Governance Programme Report ARAC 240625
- 12 12:40 – Non-compliance with Standing Orders

Non-compliance with Standing Orders

- 12.1 12:45 – LUNCH
- 13 13:35 – 2024–25 Annual Accounts and Annual Report and Recommendation to Trust Board
- 13.1 2024–25 Annual Audited Accounts
 - 2024–25 Annual Accounts Report Executive Summary –ARAC 24th June 25
 - Appendix 1 WAST Audited Accounts 2024–25
- 13.2 2024–25 Annual Report
 - Annual Report 2024–25 for ARAC 240625
 - Final Annual Report 2024–25 for ARAC and TB June 2025 – Copy for ARAC 240625
- 13.3 Audit Report, 2024–25 Accounts (Inc. Letter of Representation)
 - Item 13.3 WAST Audit of Accounts Report 2024–25
- 13.4 14:20 – CONSENT ITEMS / CLOSING ITEMS
- 14 Cycle of Business Monitoring Report and Review of Priorities 25/26
 - ARAC Priorities and Cycle Monitoring Report – June 2025
 - ARAC Cycle of Business Monitoring Report – June 2025
 - ARAC Cycle of Business Monitoring Report 2025–26 Cycle Notes
- 15 Reflections and Summary of Decisions/Actions
- 16 Any Other Business
- 17 Date & Time of the Next Meeting: 4 September 2025

Length of Meeting:	04:45	Agenda Status:	[OPEN] AUDIT, RISK AND ASSURANCE COMMITTEE - 24 JUNE 2025					Deadline for Papers:	13 June 2025
Time	Mins allotted	Agendum	Title	Format	Item for	Item requested by	Paper prepared by	Item presented by	Colleagues to cc
OPENING ITEMS									
09:45	00:05	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: 1 May 2025	Paper	Approval	Standing	n/a	Chair	n/a
		4	Action Log & Matters Arising: 4.1 Action Log 4.2 Committee AAA Report	Paper	Discussion	Standing	n/a	Chair	n/a
FOR APPROVAL, ASSURANCE AND DISCUSSION									
09:50	01:00	5	5.1 Annual Head of Internal Audit Opinion 2024/25 5.2 Internal Audit Reports: 5.2.1 Follow Up Audit on 2024/25 (Trish Mills) 5.2.2 Contract Management (Chris Turley/Trish Mills) 5.2.3 Seasonal Modelling and Forecasting (Hugh Bennett) 5.2.4 Start of Shift Procedure (Lee Brooks) 5.2.5 Emergency Nurse Communications System Implementation (Lee Brooks) 5.2.6 Capital Systems (Chris Turley)	Paper	Assurance	CoB	Internal Audit	Osian Lloyd	
10:50	00:30	6	6.1 Audit Wales Update Report 6.2 Urgent and Emergency Care Review (Liam Williams)	Paper	Assurance	CoB	External Audit	Fflur Jones	n/a
11:20	00:15	COMFORT BREAK							
11:35	00:15	7	Risk Management Report	Paper	Assurance	CoB	CorGov	Julie Boalch	n/a
11:50	00:20	8	Audit Tracker	Paper	Assurance	CoB	CorGov	Trish Mills	Lisa Trounce
12:10	00:10	9	Losses and Special Payments	Paper	Assurance	CoB	FinCor	Chris Turley, Ed Roberts	Jessica Price
12:20	00:10	10	NHS Wales No PO No Pay Policy	Paper	Approval	Ad Hoc	FinCor	Chris Turley, Ed Roberts	n/a
12:30	00:10	11	Integrated Governance Programme	Paper	Assurance	Ad Hoc	CorGov	Trish Mills	Julie Boalch, Alex Payne
12:40	00:05	12	Non-compliance with Standing Orders	Paper	Assurance	Ad Hoc [270525]	CorGov	Trish Mills	Alex Payne
12:45	00:50	LUNCH							
13:35	00:45	13	2024-25 Annual Accounts and Annual Report and Recommendation to Trust Board 13.1 2024-25 Annual Audited Accounts 13.2 2024-25 Annual Report 13.3 Audit Report, 2024-25 Accounts (Inc. Letter of Representation)	Paper	Endorsement	CoB	FinCor	Ed Roberts Trish Mills Audit Wales	Alex Payne
CONSENT ITEMS									
14:20	00:00	14	14 Committee Monitoring Report and Priorities Update 2025-26 14.1 Cycle of Business Monitoring Report 14.2 Cycle of Business Notes	Papers	Information	CoB	CorGov	Trish Mills	Alex Payne
CLOSING ITEMS									
14:20	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: 4 September 2025	Verbal	Information	Standing	n/a	Chair	n/a
14:30	04:45	CLOSE							

LEAD PRESENTERS

Name	Position
Julie Boalch	Assistant Director of Governance and Risk
Peter Curran	Non-Executive Director and Committee Chair
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
Ed Roberts	Interim Assistant Director of Finance

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	Non-Executive Director * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1995		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	Non-Executive Director * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership 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		
		Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
CURRAN, Peter	Non-Executive Director * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	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	31 October 2024	
		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		
		Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015		
DENNIS, Colin	Chair of Trust Board and Non-Executive Director * Chair of Remuneration Committee	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 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		
		<i>[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]</i>	Directorships	12 March 2020		
		Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		<i>[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]</i>	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 - Glyncomel 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		
HUTCHINGS, Hayley	Non-Executive Director * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995		
HITCHON, Estelle	Director of Partnerships and Engagement	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025		

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 the People and Culture Committee * Member of the Charity 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		
		Chairperson – Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	September 2024		
		Company Director of the Association of Ambulance Chief Executives (AACE), Co No. (07761209)	Directorships	September 2024		
		Officer of the Order of St John	Any Other Interest	January 2024		
		Member of the Order of St John	Any Other Interest	2009	2024	
KNEESHAW, Carl	Director of People	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	Director of Culture Change	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	05 November 2024	
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		



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

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 THURSDAY 1 MAY 2025 IN CARDIFF MRD AND VIA TEAMS

Meeting Commenced at 09:30

PRESENT:

Peter Curran	Non-Executive Director and Committee Chair
Rhiannon Beaumont-Wood	Non-Executive Director and Vice Chair of the Trust Board
Ceri Jackson	Non-Executive Director

IN ATTENDANCE:

Jayne Beeslee	Non-Executive Director (Left after Item 20/25)
Julie Boalch	Assistant Director of Corporate Governance and Risk
Bethan Evans	Non-Executive Director (Left after item 20/25)
Christian Fox	Trade Union Partner
Fflur Jones	Audit Wales
Angela Lewis	Director of Culture Change (Item 21/25 only)
Osian Lloyd	Head of Internal Audit, NWSSP
Trish Mills	Director of Corporate Governance/Board Secretary
Carl Kneeshaw	Director of People
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Jessica Price	Head of Financial Accounting
Felicity Quance	Internal Audit
Jonathan Sweet	Head of Service OD
Yvonne Thomas	Audit Wales
Lisa Trounce	Head of Compliance and Assurance
Chris Turley	Executive Director of Finance and Corporate Resources
Liam Williams	Executive Director of Quality and Nursing (Left after item 22/25)

OBSERVERS:

Skye Banks	Compliance Administrator

APOLOGIES:

Judith Bryce	Assistant Director of Operations
Damon Turner	Trade Union Partner
Carl Window	Local Counter Fraud Manager

19/25 PROCEDURAL MATTERS

The Chair welcomed all to the meeting, noting the apologies of Judith Bryce, Damon Turner and Carl Window.

Minutes: The Minutes of the Audit, Risk and Assurance Committee (ARAC) meeting held on 6 March 2025 were approved.

Action Log:

Action Number: 3/25 - Internal Audit Report: Roll out of Pentrox. The environmental benefits of reducing Entonox use were discussed, with Pentrox contributing to a lower carbon footprint. *Ceri Jackson queried if the carbon footprint impact was being captured and were there any indicators being taken to the Finance and Performance Committee (FPC).* It was agreed that in terms of reporting medical gases, Ed Roberts advised this was reported through the Decarbonisation Action Plan. In terms of the metrics being reported to FPC it was agreed this would be investigated further and an update provided for the next ARAC meeting. This was part of the decarbonisation report, which was reported through FP&C and the use of Entonox has reduced following the introduction of Pentrox. Agreed that the action was closed.

Action Number: 3/25a – Internal Audit Reports: Trish Mills suggested that it would be helpful to lift out specific sections of the triple-A reports from committees like Finance and Performance (F&P) and share them with the Audit, Risk, and Assurance Committee (ARAC) to ensure that discussions on internal audit reports are transparent and integrated across committees. This approach would also involve informing other committees, such as Quest, about discussions that took place in ARAC. This suggestion was agreed upon to enhance the flow of information and ensure comprehensive oversight. *This will be taken forward by the Corporate Governance Team where reports have already been received by a committee, to ensure that the discussion/outcome was fed into subsequent committees.* As this was in the work programme it was proposed for closure. Agreed that the action was closed.

Action Number: 6/25 – Audit Tracker: Revised Audit Dates: Trish Mills agreed to discuss with the Executive Leadership Team whether to remain with three revised dates, reduce them to two, and then report back to the Audit and Risk Assurance Committee (ARAC). *The preference from the ELT was that the maximum permitted revised dates should be two, as opposed to three. The Audit Tracker format will be adjusted from 2025/26 onwards.* Given the position has been reached, subject to the ARAC being content with the position, this action was proposed for closure. Agreed that the action was closed.

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

Committee AAA Report: March 2025: The Committee AAA report dated 6 March 2025 was received.

RESOLVED: The Committee:

- (1) **Noted the apologies of Judith Bryce, Damon Turner and Carl Window**
- (2) **Approved the Minutes of 6 March 2025.**
- (3) **Noted the update on the actions as described.**
- (4) **Noted there were no further declarations of interests recorded other than those listed on the Register of Interests.**
- (5) **Received the committee AAA dated 6 March 2025.**

20/25 ANNUAL BOARD AND COMMITTEE EFFECTIVENESS REVIEWS 2024/25 (ALL COMMITTEES)

Trish Mills presented the Annual Committee Effectiveness Reviews for 2024/25.

Trish Mills stated that the Trust Board will receive a report on the effectiveness of its committees (and its own effectiveness) at its 29 May meeting, as well as all committee annual reports and terms of reference for approval. All the committees' terms of reference have been amended to include a specific strategic development and delivery section.

Part one

This update included the finalised 2024/25 annual report for the Audit, Risk and Assurance Committee (ARAC), and its amended terms of reference and cycle of business for 2025/26 following a review of these at the 06 March 2025 meeting. Updates to these documents following that meeting included discussions on its effectiveness in the meeting and changes to terms of reference and operating arrangements as a result. These documents were for the committee's approval and presentation to the board on 29 May 2025. Members were asked to consider priorities for the committee for 2025/26.

Following a discussion ARAC members welcomed the continuous review through ARAC Non- Executive Director (NED) meetings as opposed to the more formal review completed in previous years. Members also acknowledged the huge amount of work involved. They also noted that the approach to committee effectiveness was thorough, positive and constructive. Members approved the changes to the terms of reference, the 2024/25 annual report and the cycle of business for 2025/26, for the ARAC.

Members considered and discussed ARAC's priorities for 2025/26 which included a focus on the further work to streamline the committee structure, and the relates changes to the Trust's Board Committee framework, during 2025/26.

Part two

Trish Mills advised that part two provided an overview of the effectiveness of the other committees. This was in line with the ARAC's purpose to advise and assure the Trust Board and the Accountable Officer on whether effective arrangements were in place to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives.

Each committee had reviewed its terms of reference and assurance reporting arrangements, alongside benchmarking against committee structures in other UK ambulance services. Following this comprehensive review it has been concluded that the areas of oversight and scrutiny delegated by the board were appropriate for the Trust's size and complexity. Annexes five to 10 were presented, with Annex 11 detailing the learning from these reviews. This will be incorporated into the Governance Directorate's Local Directorate's Plans (LDP) so that progress is monitored. It was noted that Annex 11 would be reviewed again by ARAC in September to track progress. All committees were effective in the way in which they operated, noting they all met as scheduled, that each meeting met quorum, delivered extensively and diligently on their delegated responsibilities, and have reflected on changes that would make them more effective and add value. All committees have endorsed their terms of reference for 2025/62, approved their annual reports for 2024/25, and their cycles of business for 2025/26. It was noted that within the extensive annual review across the committee framework, there were no material changes proposed at this time with regards to the number or remit of the committees. There are opportunities for development of the Board Committee framework however, with reference to the Academic Partnership Committee (APC).

It was noted that in Q1 and Q2, further work will be undertaken on the opportunities for development. This will include a fresh look at the spread across committees to affect material change to frequency and volume, and to address areas of concern related to quoracy and resilience. A core group, including ARAC NEDs, the Executive Director of Finance and Corporate Resources, and the Director of Corporate Governance/Board Secretary, will guide this work with the results reported back to ARAC in September 2025.

In addition to the Chair of ARAC, Chairs of the Finance and Performance Committee (FPC), Quality, Patient Experience and Safety Committee (QuEST) Committee, Charity Committee (CC) and People and Culture Committees (PCC) were in attendance to speak to their annual reports and the outputs of the annual effectiveness reviews, as well as to provide their views on the process and outputs of this year's reviews.

The Chairs welcomed the shift in terms of reference to a more strategic overview and recognised the nuances and responsibilities of each committee. It was suggested there could be a focus on identifying specific areas within the committees that warranted a deeper dive; with the aim to apply appropriate scrutiny to these issues while

maintaining the natural rhythm of the committee's agenda. The new approach of facilitated discussions using MENTIMETER was very effective and positive, fostering open conversations where people could share and explore ideas.

Trish Mills added that themed agendas at the commissioning stage have proven effective, creating a cohesive "golden thread" throughout. This approach helped maintain focus and structure. Going forward, the aim was to continue this practice, ensuring themes ran through committee work and incorporating deep dives as needed.

From the PCC perspective, Carl Kneeshaw added it was valuable to hear from people about their lived experiences, whether positive, negative, or neutral. Furthermore, involving Trade Union (TU) partners in these committee discussions was crucial for effective partnership working.

Liam Williams added that compiling the agendas, particularly for QuEST, involved ensuring that the most relevant and appropriate items were included, despite the volume of submissions. He made the point that at every QuEST Committee meeting it began with a patient's story, highlighting the care involved in working with the family and colleagues.

In terms of the Remuneration Committee, Trish Mills advised it was primarily reactive, dealing with annual objectives and eligibility, as well as unpredictable changes, especially at the executive level and exit settlements. Previously, meetings were infrequent, leading to a backlog of minutes. Now, the committee meets quarterly, ensuring meetings were short, effective, and papers were succinct.

Ceri Jackson accepted that while the Equality Quality Impact Assessment (EqIA) process was generally robust, added that timing can sometimes be an issue. She had noted during her review of the effectiveness review it became clear that capturing this as a priority was essential and sought clarity on the process involved. It was agreed that Trish Mills would provide further guidance on the completion of EqIAs as a substantive item at the next meeting.

Following a query on the well-being objectives, Trish Mills explained that the Strategic Transformation Board ensured a long-term view of the three main well-being objectives. The Trust's new report front covers – which will be implemented in the coming weeks – includes reference to both Trust's overarching strategic and well-being objectives, which will aid the audience's reading of papers going forward as it requires report authors to indicate the relevant objectives.

Trish Mills reported that the Welsh Ambulance Services Partnership Team (WASPT) annual effectiveness review conducted in March, that the outcome confirmed the committee remained effective and has not undergone significant change.

Committee members thanked the Corporate Governance Team, Chairs and all members of committees for their engagement in this important work. Audit Wales and Internal Audit also commended the transparent approach and thoroughness of the reviews. Fflur Jones, Audit Wales Auditor, noted that she had taken a keen interest in the discussions today for information which will inform the 2025 Structured Assessment. Fflur praised the Trust's open-minded approach to effectiveness reviews and the assurance that this gives the Trust Board regarding the effectiveness of the operation of the Board Committees. Fflur noted the Trust's willingness to take consider fundamental changes rather than just making tweaks and noted the positive integration of well-being objectives throughout the work of the committees. It was noted that Audit Wales would be considering the inclusion of well-being objectives within the 2025 Structured Assessment.

RESOLVED: The committee:

- (1) Reviewed and approved changes to ARAC's terms of reference at Annex 2 and its operating arrangements as set out in its annual report.**
- (2) Discussed and agreed the committee's priority for 2025/26.**
- (3) Approved the committee's annual report at Annex 1.**
- (4) Approved the committee's cycle of business at Annex 3.**
- (5) Noted the future work to be carried out on streamlining committees in Q1 and Q2.**
- (6) Noted the changes to the operating arrangements at Annex 11 and terms of reference at Annexes 5 to 10 for:**
 - Charity Committee**
 - Finance and Performance Committee**
 - People and Culture Committee**
 - Quality, Patient Experience and Safety Committee**
 - Remuneration Committee****and endorsed these and the annual reports for onward approval by the Trust Board and Corporate Trustee (for Charity Committee).**
- (7) Noted the progress against the changes to operating arrangements agreed following the 2023/24 effectiveness reviews and further work on conducting board visits pan-Wales.**

21/25 INTERNAL AUDIT REPORTS

Osian Lloyd gave an update on the Internal Audit Progress Report explaining that out of 20 planned reviews, 13 were completed and included in today's papers, with reasonable outcomes with seven reviews still in progress.

The 111 Wales review has been delayed due to technical issues however, this will not affect the ability to provide an opinion to the Trust.

In terms of Key Performance Indicators there has been an Improvement in the manager response indicator from Red to Amber, but a slight dip in the report turnaround indicator from Green to Amber. Efforts were ongoing to return this to Green.

Risk Management and Board Assurance Framework –Reasonable Assurance

Felicity Quance explained that the purpose of this review was to assess the effectiveness of the procedures for identification, management and reporting of the strategic and key operational risk through the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR). The key finding was that the current BAF would develop in 2025 into a strategic BAF that will focus more explicitly on its strategic objectives.

All six objectives in the audit were rated 'reasonable assurance.' The only matter requiring management attention was the need to ensure risk management documentation was updated to reflect the changes in approach that were envisaged in the coming months.

Trish Mills explained that in terms of the remaining Risk Appetite Statements, these were being finalised. Furthermore, the recruitment for a Risk Manager has been challenging, and once filled, will create more capacity to focus on the BAF.

Julie Boalch welcomed the pragmatic approach to this audit highlighting that key risks were being reported effectively through board committees. Despite challenges with the electronic system (Datix Risk Module), mechanisms were in place to support reporting.

Occupational Health and Wellbeing Support – Reasonable Assurance

Felicity Quance explained that the purpose of this review was to evaluate the programmes in place at the Trust to improve the Occupational Health and Wellbeing services and promote staff wellbeing, and arrangements in place to monitor effectiveness.

Despite efforts to achieve a 6% sickness absence target, the Trust's rates remained higher than NHS England Ambulance Services, with recent figures showing an 8% sickness rate compared to NHS England's 6.5%. The implementation of the Health and Wellbeing Plan approved in November 2024 and the occupational health and wellbeing referral system, aimed to improve the timeliness of the support provided.

All four objectives in the audit were rated 'reasonable assurance' and there were four medium priority management actions raised. These included the need for detailed deliverables in the Health & Wellbeing Plan, enhanced performance reporting, improved reporting to assess the quality and impact of initiatives, and regular feedback from managers on attendance management training sessions.

Members noted the importance of addressing musculoskeletal issues, particularly for staff in sedentary roles, and the need for leadership and management to encourage physical breaks away from desks. Additional assurance was provided on proactive measures, including increased physiotherapy referrals and improved performance for referral to first contact.

Carl Kneeshaw commented that the PCC had an oversight of the audit actions. The next steps included a continued focus on proactive health and wellbeing measures and regular updates to PCC on metrics and deep dives into absence management and occupational health usage.

Rhiannon Beaumont-Wood raised the issue of musculoskeletal (MSK) issues involving staff, particularly those whose roles were primarily sedentary and if there was a management focus on prevention. Liam Williams confirmed there were several measures in place in respect of MSK, which included encouraging staff in these roles to take regular breaks.

Speaking Up Safely– Reasonable Assurance

Felicity Quance commented that the purpose of this audit was to review the implementation of the framework and assess its impact in promoting a culture that enabled staff to effectively and openly raise concerns.

The NHS Wales Speaking Up Safely (SUS) Framework (WHC/2023/036) highlighted the importance of fostering a culture where individuals could raise concerns without fear of victimisation or detrimental treatment. The Trust has implemented several measures to support this, including the appointment of a lead Guardian and the use of the Work in Confidence (WIC) platform to record and manage concerns. Following high-profile cases, the Welsh Government (WG) has mandated NHS organisations to undertake self-assessments against the framework and develop action plans to address any gaps.

Three objectives in the audit were rated 'reasonable assurance' and one (review and analysis of recurring themes and trends) was rated limited assurance. There were five medium, and one high priority management action raised. Those actions included developing an action plan to address gaps identified in the self-assessment.

The committee discussed the challenges of auditing cultural impact and noted significant progress in this area. It was recognised that the Trust has made progress in addressing concerns and taking proactive action in problematic areas, noting there has been an increase in the NHS staff survey related to colleagues feeling able to raise concerns.

Angie Lewis acknowledged this audit highlighted challenges in assessing the cultural impact of the SUS framework. Angie Lewis added that the appointment of a guardian

was unique in NHS Wales, and it followed the National Guardian model used by ambulance services in England, to enhance the culture of SUS.

Angie Lewis further commented that since the audit conducted from December to January, significant progress has been made. Lessons learned will continue to be addressed, and themes will be identified in the first annual report.

Rhiannon Beaumont-Wood sought clarity if there was a sense of assurance regarding the resolution of concerns raised through this route. Angie Lewis explained she was confident concerns were being raised due to the framework being embedded and the Guardian being appointed.

Christian Fox commented that the process has become smoother and more efficient, which was a positive step. Building staff confidence and trust in the team will take time, but as the process continued to evolve, it should help in gradually building that trust.

Following a query on staff resources, Angie Lewis updated the Committee on the current staffing levels, adding that recruitment was underway for a further Speaking Up Safely Guardian, to support the existing Guardian Lizzie O'Shea. The intention is that this person would support the work of the Speaking Up Safely Guardian.

Trish Mills clarified the point on Recommendation six. The ARAC oversees whistleblowing arrangements, but SUS falls under the PCC. An annual report on SUS was not appropriate for ARAC; instead, it will be presented to PCC every six months and then to the Trust Board. The discussion from this meeting will be captured and included in a front cover to accompany the report, ensuring continuity and crossover.

RESOLVED: The committee received the following Internal Audit reports: Risk Management and Board Assurance Framework, Occupational Health and Wellbeing Support and Speaking Up Safely.

22/25 AUDIT WALES REPORTS

The Audit Wales progress report and Audit Plan for 2025/26 were received from Fflur Jones and Yvonne Thomas respectively.

The performance audit update included the review of Urgent Emergency Care, which was currently in clearance. Fieldwork was due to begin on the review of Digital Systems to support transformation, with the project brief now issued and agreed. The 2025 Structured Assessment associated deep dive on managing estates and local review of Non-Emergency Patient Transport service would begin later in the year.

Audit Plan for the financial accounts:

In presenting the report Yvonne Thomas outlined the risks identified during planning which included the risk of management override, which was a mandated risk included in all audit plans. Specific risks for the Trust included property, plant, and equipment and intangible assets. The audited accounts are due to be presented to the board on 26 June 2025 and the Auditor General scheduled to sign off the accounts on 27 June 2025. There were no significant issues to highlight to the board at this stage. The audit fee has been slightly increased this year due to the potential for additional work around property, plant, and equipment and intangible assets.

Chris Turley explained that the Finance team have reviewed the detailed final audit plan and found no concerns. A slight variance in the fee needs to be managed, but it was not material. The draft accounts will be submitted by the deadline, and detailed audit work will start after the bank holiday.

Ceri Jackson asked in respect to the transfer and discharge work whether the commissioning context was considered. Fflur Jones advised that as part of the unscheduled care it would consider it from the Joint Commissioning Committee perspective.

RESOLVED: The Committee received the Audit Wales update reports and the detailed audit plan.

23/25

SELF-ASSESSMENT AGAINST THE CORPORATE GOVERNANCE CODE FOR CENTRAL GOVERNMENT DEPARTMENTS 2017 - 2025 REVIEW

Trish Mills gave assurance that the Trust was compliant with all elements of the Corporate Governance Code for Central Government Departments 2017 as stated in the Trust Annual Report that would come to Board in June. There were no elements currently showing as 'explain'. Trish Mills verified that this was another element of the effectiveness review, which the board will have sight of.

Trish Mills added that it will be referred to in the AAA and agreed it would be sent to the Chair of the Board.

RESOLVED: Members Reviewed the 2024/25 self-assessment against the Corporate Governance Code for Central Government Departments 2017, ahead of confirming compliance with the Code in the 2024/25 Accountability Report.

24/25

REGISTERS

The following two Registers were presented to the Committee by Trish Mills:

Annual Report on Board Member Register of Interests 2024/25

The Trust's Standing Orders provision 8.1 requires all Board Members to declare any personal or business interests they may have which may affect or be perceived to affect the conduct of their role as a board member.

Gifts, Hospitality & Sponsorship Register 2024/25

Standing Order 8.7 requires the Director of Corporate Governance/Board Secretary "on behalf of the Chair, to maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members.

The Registers will now be made publicly available on the Trust website. The increase in reporting gifts and hospitality requests was noted. This importance of transparency, especially with suppliers, and the efforts to improve communication around gifts, hospitality, secondary employment, and sponsorship was recognised.

The committee recognised that it was a requirement of Trust's Standing Orders and the Committee's Terms of Reference that the Registers be received by the Committee at least once annually.

RESOLVED: The Committee confirmed receipt of the Trust Board Register of Interests as at the 31 March 2025 and confirmed receipt of the Gifts, Hospitality, Sponsorship Register as at the 31 March 2025.

25/25 RISK REPORTING SCHEDULE - 2025/26

Julie Boalch explained that the 2025/26 schedule considered the six Board meetings ensuring there was no duplication of reporting at any Board or Committee so that all forums were receiving the most up-to-date information and was here for approval. The committee approved the revised risk reporting schedule for 2025/26.

RESOLVED: The revised Risk Reporting Schedule for 2025/26 was approved.

26/25 REFLECTIONS AND SUMMARY OF ACTIONS

Members reflected that the particular focus on the annual board and committee effectiveness review demonstrated the substantial, excellent work delivered by the Board Secretary and the wider Corporate Governance Directorate. The outputs of this provided significant assurance to the committee of the effectiveness of the current board and committee arrangements. Members commented on the positive, constructive and collaborative nature of the meeting, noting the excellent collaboration with Internal and External Auditors.

Meeting concluded at 12:30

Date of next meeting: 24 June 2025

DRAFT

ACTION LOG
WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST - AUDIT, RISK AND ASSURANCE COMMITTEE

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
20/25	1 May 2025	Annual Board and Committee Effectiveness Reviews 2024/25 (All Committees	Ceri Jackson requested further details on the governance process in terms of EqlA's. It was agreed that Trish Mills would provide further guidance on the completion of EqlA's as a substantive item at the next meeting.	Trish Mills	24 June 2025	<u>24/06/2025</u> TM Update: The Trust has published an impact assessment guidance document -published via a Siren notice - which has been shared for the committee's information. This will be noted at the meeting. Subject to the committee being content with this position, the action is proposed for closure.	Complete



Corporate Governance Directorate Notice

21 February 2025

IMPACT ASSESSMENTS

Impact assessments are required in the following circumstances:

- Strategic decisions and policies: These require an Equality Impact Assessment (EqIA); and
- Projects, programmes, procurement etc: These require situational specific impact assessments.

STRATEGIC DECISIONS AND POLICIES REQUIRING AN EQIA

What is a strategic decision? There is no one definition that relates to impact assessments, however the Equality Act 2010 says that decisions of a strategic nature will be those which affect how WAST, as a public body, fulfils its intended statutory purpose over a significant period of time. It does not include routine day-to-day decisions. Such decisions are usually delegated to senior management or the Trust Board.

If you are seeking approval for a strategic decision, or developing a policy for approval, an Equality Impact Assessment (EqIA) must be done. An EqIA ensures that all significant decisions are made with an informed awareness of their potential impacts on protected characteristics, especially concerning equality. Because of this they should be done at the start of your project/policy to inform its development.

The EqIA should be included with documents presented to decision-makers, ensuring it is completed before any decisions are finalised.

Strategic decisions *may* also require a Quality Impact Assessment (QIA) however, unlike the EqIA, not all strategic decision will need a QIA (see below). When considering completion of an EqIA or QIA, it is important to review the available data and existing information flows that might help demonstrate how the impact would be measured and variation identified.

The overriding requirement for decisions of a strategic nature under the Health and Social Care (Quality and Engagement) Act 2020 is that such decisions are made through the lens of improving the quality of health services and outcomes for the population. Linking the rationale for such decision to the Health and Care Quality Standards may suffice, and where a QIA is required, this will be on the advice of the clinical executive leadership or senior quality leads.

These are examples of when you will need an EqIA

- Long term strategy
- Directorate/speciality specific plans such as the Digital Plan, or the Strategic Workforce Plan
- Integrated Medium Term Plan (IMTP) and related financial plans
- OCPs and similar plans that affect our people
- Policies
- Service change and development of public services
- Major business cases of a strategic nature
- Closure of stations or offices/places of work
- Major procurement and commissioning decisions

Some of the above may need more than just an EqIA. For example, a clinical model transformation may also need a QIA, and a major procurement may also need a Data Protection Impact Assessment or an Environmental Impact Assessment.

If in doubt, or for further details on EqIAs, please consult the Equality, Diversity and Inclusion tab on the People Services Siren page here [Equity, Diversity & Inclusion](#) or contact the team by email on amb_inclusion@wales.nhs.uk.

OTHER IMPACT ASSESSMENTS

Some decisions you require may be less strategic and more operational or situational or programme specific in nature. However, you may still need to do an impact assessment. The following are the most likely you should consider:

Quality Impact Assessment (QIA)

The Health and Social Care (Quality and Engagement) Wales Act 2020 requires us to must manage our functions to enhance the quality of healthcare services. Adhering to the statutory guidance and Health and Care Quality Standards, decision-making should be quality-focused, strategically aligned, and verifiable through an audit process.

For major clinical changes or alterations to service models, a comprehensive QIA is essential. In other instances, conducting just the screening part of a QIA or clear demonstration of adherence to the Health and Care Quality Standards may suffice.

Decisions that might require a QIA are typically identified through clinical or quality pathways. Senior quality leads or clinical and quality executive leads provide guidance on whether a full QIA or a simpler screening QIA is needed.

If in doubt, or for further details on QIAs, please consult the Quality, Safety and Patient Experience Siren page here [Quality Impact Assessment Guidelines and Template](#) or contact the team email on Amb_qualitymanagementgroup@wales.nhs.uk.

Data Protection Impact Assessment (DPIA)

The DPIA Screening Checklist must be completed for any new projects or changes to processes involving personal data.

The Checklist is a high-level screening test to screen for any flags which indicate that you need to do a full DPIA to look at the risk in more detail and to ensure legal compliance. The checklist must be conducted before initiating any processing activities.

If in doubt, or for further details on DPIAs, please consult with the Digital Team Siren page at [Data Protection Impact Assessments \(DPIA\)](#) or email the team at AMB_infoGovernance@wales.nhs.uk.

Environmental Impact Assessment (EIA)

There are specific requirements to do an EIA in the following circumstances:

- A Sustainability Risk Assessment is required for tenders above £25K with NWSSP. This is an internal process with NWSSP and is not approved by them or WAST, nor is any feedback received from NWSSP.
- A Sustainability Impact Assessment is required for large-scale new builds and major refurbishments, complying with building regulations and local authority requirements.
- A WAST specific EIA is required where there are environmental impact assessments for WAST of large-scale projects or procurements not covered by the above.

If in doubt, or for further details on EIAs, please consult the Finance and Corporate Resources Siren page at [Finance and Corporate Resources](#) or email the team on amb_estates_helpdesk@wales.nhs.uk.

Cyber Assessment Framework (CAF)

The CAF must be completed for all projects that involve new critical digital systems whether on premise or in the cloud. This provides a comprehensive and systematic approach to assessing cyber risk and resilience of a digital system.

A cloud security assessment must be completed for any digital systems that are cloud-based.

A supplier due diligence questionnaire is required to be completed at procurement stage for any suppliers who will providing digital services, systems or products.

If in doubt or for further details please contact amb_cybersecurityteam@wales.nhs.uk.



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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	29 May 2025
Committee Meeting Date	1 May 2025
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. The board will note that this first of five ARAC meetings in 2025/26 is dedicated to governance issues, particularly the annual committee effectiveness reviews, the self-assessment against the Corporate Governance Code and registers related to the Standards of Business Conduct Policy. For this reason, some of the usual standing items are not presented.

ADVISE

(Detail any areas of on-going monitoring, approvals, or new developments to be communicated)

2. A **pre-meet** was held with Audit Wales, Internal Audit and the committee Chair ahead of the meeting.
3. The **Audit Wales** progress report and Audit Plan for 2025/26 were received. Materiality with respect to the **audit of the financial accounts** is set at 1% of gross expenditure, with lower materiality for areas deemed more important to the users of the accounts, such as remuneration of senior officers and related party disclosures. Risks identified during planning include the risk of management override, which is a mandated risk included in all audit plans. Specific risks for the Trust include property, plant, and equipment and intangible assets. The audit will begin on 7 May following receipt of the accounts on 2 May. The deadline for completing the audit has been moved forward two weeks this year, with the audited accounts presented to the board on 26 June and the Auditor General scheduled to sign off the accounts on 27 June. There are no significant issues to highlight to the board at this stage.

The **performance audit** update included the review of urgent emergency care, which is currently in clearance. Fieldwork is due to begin on the review of digital systems to support transformation, with the project brief now issued and agreed. The 2025 structured assessment associated deep dive on managing estates and local review of non-emergency patient transport service will begin later in the

year.

The audit fee has been slightly increased this year due to the potential for additional work around property, plant, and equipment and intangible assets.

4. Members **reflected** that the particular focus on the annual board and committee effectiveness review demonstrated the substantial, excellent work delivered by the Board Secretary and the wider Corporate Governance Directorate. The outputs of this provided significant assurance to the committee of the effectiveness of the current board and committee arrangements. Members commented on the positive, constructive and collaborative nature of the meeting.

ASSURE

(Detail here any areas of assurance the Committee has received)

5. The **Annual committee effectiveness reviews for 2024/25** were received. This committee approved its annual report and terms of reference following discussion on its effectiveness in March.

The board will receive a report on the effectiveness of its committees (and its own effectiveness) at its 29 May meeting, as well as all committee annual reports and terms of reference for approval, however the following key issues were discussed by members of ARAC:

- The extensive reviews of terms of reference, assurance reporting, and operating arrangements across all seven committees provided an all-encompassing view of the areas of oversight and scrutiny that is delegated by the board. ARAC is of the view that this is an appropriate spread for WAST's size and complexity.
- All committees are effective in the way in which they operate, noting that they all met as scheduled, were quorate for each meeting, delivered extensively and diligently on their delegated responsibilities, and have reflected on changes that would make them more effective and add value.
- In addition to the Chair of this committee, Chairs of the Finance and Performance Committee, QUEST Committee, Charity Committee and People and Culture Committees were in attendance to present their annual reports and provide their views on the process and outputs of the reviews. All welcomed the shift in terms of reference to a more strategic overview.
- Further work will take place in Q1 and Q2 on the opportunities that arise in the Academic Partnerships Committee reaching its natural crossroads. This includes a fresh look at the spread across committees in an attempt to affect material change to frequency and volume, and to address areas of concern related to quoracy resilience. The core group of ARAC NEDs, Executive Director of Finance and Corporate Resources (committee lead) and Director of Corporate Governance/Board Secretary will be the sounding board for this work and the outputs will come back in September.

ARAC thanked the Corporate Governance Team, Chairs and all members of committees for their engagement in this important work. Audit Wales and Internal Audit also commended the transparent approach and thoroughness of the reviews.



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6. The committee received assurance that the Trust is complying with all elements of the **Corporate Governance Code 2017** as stated in the corporate Annual Report that will come to the board in June. There are no elements currently showing an 'explain' rating.
7. The Internal Audit progress report was received and members noted that turnaround times both for internal audit and the Trust are Amber. The 111 Wales Website audit is the only audit that is at risk of not being completed for 2024/25 due to temporary capacity issues with Internal Audit, however this will not affect the ability of the Head of Internal Audit to provide an overall end of year opinion.

The following Internal Audit reviews were completed during the quarter and presented to the Committee. Members reviewed the action plans that accompanied the audits and were assured they were appropriate and timely:

- **Risk Management and Board Assurance Framework – Reasonable Assurance.** The purpose of this review was to assess the effectiveness of the procedures for identification, management and reporting of strategic and key operational risk through the Board Assurance Framework and the Corporate Risk Register. The key finding is that the current BAF (essentially the Corporate Risk Register, but in more detail and linked to the IMTP) will develop in 2025 into a strategic BAF that will focus more explicitly on its strategic objectives. Notwithstanding this concern, the reporting of the current key risks in the BAF through the Board and its Committees is working effectively. Findings have not been raised with respect to the strategic BAF and risk appetite as the oversight of these programmes of work sit with this committee.

All six objectives in the audit were rated 'reasonable assurance' with the only matter requiring management attention being the need to ensure risk management documentation is updated to reflect the changes in approach that are envisaged over the coming months.

- **Occupational Health and Wellbeing Support – Reasonable Assurance.** The purpose of this review was to evaluate the programmes in place at the Trust to improve the Occupational Health and Wellbeing services and promote staff wellbeing, and arrangements in place to monitor effectiveness.

Despite efforts to achieve a 6% sickness absence target, the Trust's rates remain higher than NHS England Ambulance Services, with recent figures showing an 8% sickness rate compared to NHS England's 6.5% (however there was caution proposed by ARAC given England's different operating context). There has historically been a low uptake of support services, including management of referrals to Occupational Health and Wellbeing provision. The implementation of the Health and Wellbeing Plan approved in November 2024 as well as the occupational health and wellbeing referral system, permitting both self-referrals and manager referrals, aim to improve the timeliness of the support provided.

All four objectives in the audit were rated 'reasonable assurance' and there were four medium priority management actions raised. These included the need for detailed deliverables in the Health & Wellbeing Plan, enhanced performance reporting, improved reporting to assess the quality and impact of initiatives, and regular feedback from managers on attendance management

training sessions. A verbal update confirmed actions due by the end of Q4 had been completed.

Members noted the importance of addressing musculoskeletal issues, particularly for staff in sedentary roles, and the need for leadership and management to encourage physical breaks. Additional assurance was provided on proactive measures, including increased physiotherapy referrals and improved performance for referral to first contact.

The People and Culture Committee has an oversight of the audit actions and will receive this report at its May meeting. Next steps include continued focus on proactive health and wellbeing measures and regular updates to that committee on metrics and deep dives into absence management and occupational health usage.

- **Speaking Up Safely – Reasonable Assurance.** The purpose was to review the implementation of the framework and assess its impact in promoting a culture that enables staff to raise concerns.

The NHS Wales Speaking Up Safely (SUS) Framework (WHC/2023/036) highlights the importance of fostering a culture where individuals can raise concerns without fear of victimisation or detrimental treatment. The Trust has implemented several measures to support this, including the appointment of a lead Guardian and the use of the Work in Confidence (WIC) platform to record and manage concerns. Following high-profile cases, the Welsh Government has mandated NHS organisations to undertake self-assessments against the framework and develop action plans to address any gaps. The Trust has completed its self-assessment and is working on an action plan to ensure compliance and continuous improvement – this will come into the People and Culture Committee for oversight.

Three objectives in the audit were rated 'reasonable assurance' and one (review and analysis of recurring themes and trends) was rated 'limited assurance'. There were five medium, and one high priority management action raised. Those actions include developing an action plan to address gaps identified in the self-assessment, consistently issuing surveys post-closure of SUS cases to gather feedback, enhancing training for staff to embed the framework's requirements, and triangulating concerns data from all sources for effective oversight. It was agreed that recommendation 6, an annual speaking up safely report to this committee, was not required as the ARAC responsibility for ensuring arrangements for 'whistleblowing' were in place and effective is discharged with an annual assurance report to that effect from the Chair of People and Culture Committee.

The committee discussed the challenges of auditing cultural impact and noted significant progress in this area which, for several reasons including confidentiality and the qualitative nature of information, was difficult to capture and audit. It was recognised that the Trust has made progress in addressing concerns and taking proactive action in problematic areas, noting also that there has been an increase in the NHS staff survey related to colleagues feeling able to raise concerns. The People and Culture Committee has an oversight of the audit actions and will receive this report at its May meeting.

8. The annual reports on **board members' interests and the gifts and hospitality register** were received. The registers will now be made publicly available on the Trust website. The increase in



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reporting gifts and hospitality requests was noted. This importance of transparency, especially with suppliers, and the efforts to improve communication around gifts, hospitality, secondary employment, and sponsorship was recognised.

RISK MANAGEMENT

Members approved the 2025/26 risk reporting schedule which had been aligned to the board and committee cycle.

COMMITTEE AGENDA FOR MEETING IN JUNE

Committee effectiveness reviews for 2024/25	Internal Audit Progress Report and the audit reports listed above	Audit Wales progress report and Audit Plan for 2025/26
Self-assessment against the Governance Code 2017	Annual Report on Board Member Register of Interests 2024/25 Gifts, Hospitality & Sponsorship Register 2024/25	Risk reporting schedule 2025/26

COMMITTEE ATTENDANCE

Name	1 May 2025 ¹	24 Jun 2025	2 Sep 2025	2 Dec 2025	2 Mar 2026	
Peter Curran						
Ceri Jackson						
Rhiannon Beaumont-Wood						
Chris Turley						
Audit Wales	Fflur Jones					
Julie Boalch						
Judith Bryce	Jon Sweet					
Christian Fox						
Carl Kneeshaw						
Osian Lloyd						
Trish Mills						
Liam Williams						
Carl Window						
Damon Turner						

	Attended
	Deputy attended
	Apologies received
	No longer member

¹ The chairs of the Finance and Performance Committee (Jayne Beeslee) and QUEST (Bethan Evans) were in attendance for the committee effectiveness reviews

Head of Internal Audit Opinion & Annual Report 2024/25

Welsh Ambulance Services University NHS Trust



Contents

1. Executive Summary	1
2. Head of Internal Audit Opinion	3
3. Other work relevant to the Trust	12
4. Delivery of the Internal Audit Plan	15
5. Risk based audit assignments	16
6. Acknowledgement	19
Appendix A Conformance with Internal Audit Standards	20
Appendix B Audit Assurance Ratings	22

Report status:	Final
Draft report issued:	23 May 2025
Final report issued:	12 June 2025
Author:	Osian Lloyd, Head of Internal Audit
Audit, Risk and Assurance Committee:	June 2025

1. Executive Summary

1.1 Purpose of this Report

Welsh Ambulance Services University NHS Trust (the Trust) Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation’s objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

1.2 Head of Internal Audit Opinion 2024/25

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board’s own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2024/25 is:

Reasonable assurance		The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

The plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit, Risk and Assurance Committee (the ‘Committee’). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for 2024/25 year, was presented to the Committee in March 2024. Changes to the plan have been made during the year and these changes have been reported to the Audit, Risk and Assurance Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NHS Wales Shared Services Partnership (NWSSP), Digital Health & Care Wales (DHCW), and the new NHS Wales Joint Commissioning Committee (JCC) that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023, stated we ‘Fully Conform’, and our own annual Quality Assurance and Improvement Programme (QAIP) confirmed that our internal audit work continues to ‘generally conform’ to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2024/25. We can state that our service ‘conforms to the Institute of Internal Auditors’ professional standards and to PSIAS.’

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the substantial and reasonable areas in the table below.

Where we have given Limited or Unsatisfactory Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, we also undertook advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2024/25

Substantial Assurance	• 111 Wales Digital Operations • Estates Assurance: Energy Management
Reasonable Assurance	• Risk Management and Board Assurance Framework • Follow Up of Internal Audit Recommendations • Integrated Quality Performance and Management Framework • Seasonal Modelling and Forecasting • Exposure to Fumes • Patient Experience and Community Involvement • Rollout of Penthrox • Overtime Controls • Emergency Nurse Communications System Implementation • Data Quality • Occupational Health and Wellbeing Support • Speaking Up Safely • Capital Systems

Limited Assurance	• Vehicle Accident Management • Start of Shift Procedure • 111 Wales Website (draft) • Resourcing Policy
Unsatisfactory	N/A
Advisory/Non-Opinion	• Contract Management

Please note that our overall opinion has also considered both the number and significance of any audits that have been deferred during the year and other information obtained during the year that we deem to be relevant to our work (see section 2.4).

2. Head of Internal Audit Opinion

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Quality Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Trust's risk management process and system of assurance should bring together all the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit, Risk and Assurance Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Trust. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board considers but is not intended to provide a comprehensive view.

The Board, through the Audit, Risk and Assurance Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Welsh Ambulance Services University NHS Trust which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be considered by regulators, including Healthcare Inspectorate Wales, in assessing compliance with the Health and Care Quality Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the 2024/25 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight areas that were previously used to frame the audit plan at its outset (see section 2.4).

2.4 Head of Internal Audit Opinion

Scope of opinion

As noted already, the scope of my opinion covers both those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit, Risk and Assurance Committee, and other information obtained during the year that we deem to be relevant to our work. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management, and control is set out below.

Reasonable assurance		The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised from reviews.

Focus should be placed on the agreed response to any Unsatisfactory and Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there were four in 2024/25) as well as addressing implementation of recommendations from previous year reviews.

Basis for Forming the Opinion

The audit work undertaken during 2024/25, and reported to the Audit, Risk and Assurance Committee, has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit, Risk and Assurance Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.5).
- The results of any audit work related to the Health & Care Quality Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the leadership standard.
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key Committee meetings; meetings with Executive Directors, senior managers and Non-Executive Directors; the results of *ad hoc* work

and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Trust.

In reaching this opinion we have identified some reviews during the year concluded positively with effective control arrangements operating in some areas.

From the opinions issued during the year, two were allocated Substantial Assurance, thirteen were allocated Reasonable Assurance, four were allocated Limited Assurance with none allocated an Unsatisfactory assurance opinion. One advisory or non-opinion report was also issued.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit, Risk and Assurance Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming the overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Trust's activities that we had previously used to structure our strategic and one-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

Reasonable assurance was awarded in respect of the two reviews undertaken in this area.

- **Risk Management and Board Assurance Framework (BAF):** The key finding from our review is that the BAF is essentially the Corporate Risk Register, but in more detail. The Trust are aware of this and are working with external consultants to develop a new BAF that will focus more explicitly on its strategic objectives. Notwithstanding this concern, the reporting of the current key risks through the Board and its Committees continues to work effectively.
- **Follow-up of Internal Audit Recommendations** - this audit reviewed the systems in place to monitor progress with the implementation of actions in response to internal audit reports. We also validated the stated position for a sample of recommendations within the tracker See section 2.5.
- A review of the draft **Annual Governance Statement** highlighted that it was generally consistent with our knowledge of the Trust through the audit work performed in the Internal Audit plan and a review of other organisational documents.

Strategic Planning, Performance Management & Reporting

Reasonable assurance was awarded in respect of the two reviews undertaken in this area.

- The audit of the Trust's **Integrated Quality and Performance Management Framework** highlighted the need to embed the framework to ensure its successful

delivery. Key recommendations include enhancing oversight, refining communication plans, and ensuring timely, measurable progress across the framework's implementation.

- The **Seasonal Modelling and Forecasting** audit identified that while processes are embedded in operations, key gaps exist in documentation, governance, and evaluation. Improvements are needed to clarify roles and responsibilities and to ensure there is sufficient oversight, quality assurance, and organisational learning to enhance winter resilience planning, and alignment with strategic priorities and performance expectations.

Financial Governance and Management

We have undertaken two reviews in this area.

- The advisory review of **Contract Management** compared and contrasted the appropriateness of contract management arrangements across eight organisations, with common issues and challenges noted. Recommendations focus on clarifying roles and responsibilities and improving procedures, training provision, contract registers, and performance monitoring and oversight. Collaborative action with other NHS Wales bodies and NWSSP Procurement Services is advised to enhance consistency and mitigate risks.
- Limited assurance was provided in relation to **Vehicle Accident Management**. Key issues include lack of guidance, underreporting of incidents leading to a lack of investigation, poor data integration, and limited oversight. Recommendations focus on improving reporting systems, training, documentation, and analysis to reduce incidents and enhance accountability and learning. The report also recognised that the cost of vehicle accidents to the Trust is low and it is currently in a position to better defend claims made against it.

Quality & Safety

Reasonable assurance was awarded in respect of the three reviews undertaken in this area.

- **Exposure to Fumes:** The audit provided reasonable assurance on managing staff exposure to diesel fumes at Emergency Departments as a result of handover delays, reflecting positively on the actions being taken by the Trust. Key issues include the need to update guidance and improve data collection, a lack of a work programme in place for the cyclical completion of risk assessments, staff not complying with guidance, and delayed committee reporting.
- The **Patient Experience and Community Involvement** (PECI) review provided reasonable assurance on the Trust's engagement practices, highlighting effective frameworks and meaningful initiatives. However, improvements are needed in survey design, public engagement tracking, and impact reporting. Recommendations focus on the need to better define and coordinate the PECI Team's activities, increasing feedback response rates, and ensuring service changes reflect public input for better healthcare outcomes.
- The audit of the **Rollout of Pentrox** highlighted that while policies and training provision were in place, issues included incomplete training compliance, protocol breaches, limited access primarily for Community First Responders, and lack of

impact reporting. Recommendations focus on improving monitoring, training, access, and evaluating the analgesic's effectiveness and benefits.

Information Governance & Security

We have undertaken three reviews in this area, one of which is work in progress, but is planned for inclusion within the 2024/25 opinion.

- The **111 Wales Website** (draft) review assessed whether the 111 Wales website enables secure and effective provision of patient services. Limited assurance was reported, with high priority matters raised to strengthen the position. It is recognised that development of the website, and updated symptom checkers, remain a priority for the Trust, but could not be delivered in 2024/25 as funding has not yet been agreed. However, this has rolled forward into the Trust's 2025/28 Integrated Medium-Term Plan (IMTP).
- Substantial assurance was provided following our review of **111 Wales Digital Operations**. We found that the new system is secure, resilient, and well-managed. Staff received comprehensive training, and performance is effectively monitored. While implementation was rapid, lessons were learned. No significant issues were identified, and risk management, system performance, and user support were all deemed effective.
- The **Data Quality** audit provided reasonable assurance on the Trust's processes. The focus within the Trust, due to capacity, has been on the Emergency Medical Services Computer-Aided Dispatch System (EMS CAD), 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. While EMS CAD data is well-managed, gaps exist in training, policy updates, incomplete information asset registers, and assurance reporting. Key recommendations include improving digital literacy, formalising data quality reporting, updating policies, and enhancing oversight across all systems to ensure consistent data integrity.

Operational Service and Functional Management

We have undertaken three reviews in this area.

- The review of **Overtime Controls** provided reasonable assurance. Processes for allocation, authorisation, and payment were generally sound. Key improvements include better documentation of allocation changes and exploring automation of the payment process to reduce manual input. While overtime was mostly within budget, some local variances and inefficiencies in reporting and payment processes remain.
- **Start of Shift Procedure**: This audit assessed compliance with the Start of Shift procedure, including the preparation of vehicles and to ensure that key equipment and medicines are available, and was provided limited assurance.
- Reasonable assurance was reported in relation to **Emergency Nurse Communications System Implementation**: While benefits were broadly achieved, no post implementation review has been undertaken. In addition, gaps remain in benefit definition and tracking, coverage of audit arrangements, and performance monitoring. Delays in quality assurance, inconsistent feedback, and lack of formal action plans risk accreditation. Improved governance, reporting and

escalation, and resource allocation are also recommended to strengthen oversight and outcomes.

Workforce Management

We have undertaken three reviews in this area.

- Limited assurance was provided following our review of the Trust's **Resourcing Policy**. Key issues include outdated policy, inconsistent application across services and regions, working time breaches not reviewed or reported on, unclear time off in lieu processes, and lack of performance reporting. Recommendations focus on the need to undertake a significant process mapping exercise to inform policy updates, standardising procedures, improving monitoring, and enhancing reporting to ensure compliance and operational consistency.
- **Occupational Health and Wellbeing Support:** We evaluated the programmes in place at the Trust to improve the Occupational Health and Wellbeing services and promote staff wellbeing and provided **reasonable** assurance. We found that while key strategies and support programmes are in place, improvements are needed in performance monitoring, trend analysis, and outcome evaluation. Enhanced data use and clearer measurement frameworks are recommended to better assess effectiveness and impact, and guide proactive interventions.
- The audit report on the **Speaking Up Safely** framework within the Trust provided reasonable assurance. While progress is evident, improvements are needed in action planning, feedback collection, enhanced training for managers, data capture and triangulation, and reporting. Strengthening these areas will enhance staff confidence, ensure timely resolution of concerns, and support a culture of openness and psychological safety.

Capital & Estates Management

We have undertaken two reviews in this area.

- Substantial assurance was provided following our review of the Trust's **Energy Management arrangements**. Strong governance, monitoring, and sustainability initiatives were noted. Minor issues included reliance on estimated meter readings, manual invoice approvals and display of educational media across Trust premises. Recommendations focus on expanding smart meter rollout, improving energy awareness communications, and streamlining invoice processing to enhance efficiency and accuracy.
- **Capital Systems:** While procurement and contract award processes were generally sound, resulting in reasonable assurance being awarded, gaps were noted in formal procedures, contract documentation, and retention practices. Recommendations include developing standardised project procedures, improving contract annotation and retention, and ensuring declarations of interest and non-collusion are consistently documented and retained.

2.5 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

However, it remains the role of Audit Committees, as reiterated within the Trust's Audit Handbook, to scrutinise the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

The Trust's recommendation tracking process continued during 2024/25. The Corporate Governance team has continued to review all outstanding recommendations with management and the outcomes have been reported to the Audit, Risk and Assurance Committee. The Trust also continues to refer relevant extracts of the audit tracker to each Board Committee to support oversight and scrutiny of recommendations relating to their remit. The Audit, Risk and Assurance Committee scrutinises the progress of audits recommendations overall, escalating to the Board any issues or concerns. The Trust is also developing a more automated tracker system, with support from Digital Health Care Wales.

We have undertaken work towards the end of the year to validate the stated position for a sample of recommendations within the tracker. We were able to confirm the recorded position for all sampled recommendations and therefore provide the Audit, Risk and Assurance Committee with additional assurance around the accuracy of the tracker.

2.6 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.7 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Trust, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

Most audit reviews will relate to the systems and processes in operation during 2024/25 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Trust's Annual Report and accordingly will be completed and reported to management and the Audit, Risk and Assurance Committee after this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.8 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2024/25.

2.9 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023 who concluded we 'Fully Conform' with the Standards.

The NWSSP Audit and Assurance Services can assure the Audit, Risk and Assurance Committee that it has conducted its audit at the Trust in conformance with the Public Sector Internal Audit Standards for 2024/25.

Our conformance statement for 2024/25 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2024/25 which will be reported formally in the Summer of 2025; and
- The results of the External Quality Assessment.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2024/25 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other members of NWSSP's Audit & Assurance Service who undertook work on the Trust's audit programme for 2024/25.

The Head of Internal Audit has unfettered access to the Chief Executive, Chair of the Audit, Risk and Assurance Committee and Chair of the Trust.

2.10 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to consider other assurances and risks when preparing their Statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Quality Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales, Healthcare Inspectorate Wales and Health and Safety Executive.

3. Other work relevant to the Trust

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other health bodies. These are set out below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership;
- Digital Health & Care Wales; and
- NHS Wales Joint Commissioning Committee.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NWSSP, a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Trust. These audits of the systems operated by NWSSP, processing transactions on behalf of the Trust, derived the following opinion ratings:

Audit	Opinion	Outline scope
Accounts Payable	Reasonable	To review the adequacy of the systems and controls in place for key risk areas in the accounts payable process, including progress in implementing the actions agreed with management to address the issues identified in the previous audit report.

Payroll	Substantial	To evaluate the design and operation of the systems and controls in place within payroll services.
Recruitment Services	Substantial	To review the adequacy of systems and controls in place for Recruitment Services.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. All audits in this programme are reported to the Velindre University NHS Trust Audit Committee for NWSSP. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Trust. These audits derived the following opinion ratings:

Audit	Opinion	Outline scope
Financial Sustainability	Substantial	To review the financial management arrangements in place to ensure the ongoing sustainability of services and project delivery, with a particular focus on sustainable funding requirements for projects (e.g. DPIF, WASPI).
Programme Management	Reasonable	To establish the effectiveness of the portfolio management model used by DHCW and the controls that are in place to ensure it operates across the range of active projects.
Mission One – National Data Resource	Reasonable	To provide assurance over the National Data Resource (NDR) Platform programme of work, including progress towards implementing local datastores, and reference, demographics and medicines data.
Mission One – Cloud Services	Substantial	To provide assurance over the programme of work to move live services from datacentres into the cloud.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

NHS Wales Joint Commissioning Committee (JCC)

The work at the JCC is undertaken as part of the Cwm Taf Morgannwg University Health Board internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Outline scope
Mental Health Quality Commissioning arrangements	Reasonable	The purpose of the review was to assess the effectiveness of the arrangements in the JCC to oversee the quality and safety aspects of the commissioning of mental health and learning disability placements.
Governance	Advisory	To assess the arrangements that have been put in place at the JCC for embedding the statutory governance framework and the establishment of operational governance arrangements to provide effective oversight in the new organisation.
Financial arrangements (draft)	Reasonable	To consider the financial arrangements in relation to financial management and budgetary control, procurement and income.
Review of Traumatic Stress Wales (draft)	Limited	The purpose of the review was to provide information to assist the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups within the JCC to determine the optimum delivery mechanism for the national objective of Traumatic Stress Wales (TSW), by review of the adequacy of the systems and controls in place within TSW and the JCC in relation to its management of TSW. The review sought to provide assurance to the Chief Commissioner via the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups, that TSW is operating effectively, systems are being managed appropriately, and there is clarity on the purpose and objectives of TSW within the new arrangements for the JCC.

While these audits do not form part of the annual plan for the Trust, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report, and the JCC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. Delivery of the Internal Audit Plan

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit, Risk and Assurance Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit, Risk and Assurance Committee during the year. Audits that remain to be reported, but are reflected within this Annual Report, will be reported alongside audits from the 2024/25 operational audit plan.

The audit plan approved by the Committee in March 2024 contained 20 planned reviews. As reported to the Audit, Risk and Assurance Committee, no changes have been made to the plan.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Trust. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit, Risk and Assurance Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to Audit, Risk and Assurance Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2024/25	G	March 2024	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2024/25	G	100% (20/20)	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	80% 16/20	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to discussion & draft report [15 working days]	G	74% (14/19)	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% (19/19)	80%	v>20%	10%<v<20%	v<10%

Key: v = percentage variance from target performance

5. Risk based audit assignments

The overall opinion provided in Section 1 and our conclusions on individual reviews is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 20 audit reviews were reported during the year. Figure 1 below presents the assurance ratings, and the number of audits derived for each.

Figure 1 Summary of audit ratings

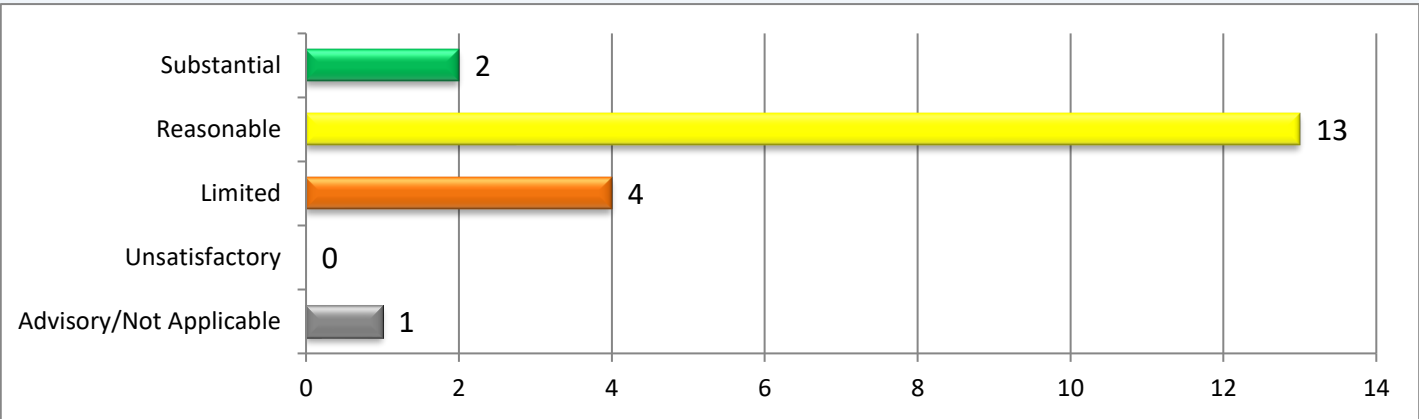


Figure 1 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW or the NHS Wales JCC.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Dark Green)



In the following review areas, the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
111 Wales Digital Operations	To assess whether the digital operation of 111 is safe and effective, with mitigation plans in place for any weaknesses identified and tracked to resolution.
Estates Assurance: Energy Management	The audit was undertaken to determine the adequacy of, and operational compliance with, the established systems for the management and control of energy consumption within the Trust and

Review Title	Objective
	also considered other supporting regulatory and procedural requirements.

5.3 Reasonable Assurance (Light Green)



In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Risk Management and Board Assurance Framework	The purpose of this review was to assess the effectiveness of the procedures for identification, management and reporting of strategic and key operational risk through the Board Assurance Framework and the Corporate Risk Register.
Follow Up of Internal Audit Recommendations	To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.
Integrated Quality and Performance Management Framework	To review the deployment of the Quality & Performance Management Framework (Framework) and assess the extent it is being embedded across the Trust.
Seasonal Modelling and Forecasting	To assess the Trust's approach to forecasting and modelling, including focus on winter resilience planning.
Exposure to Fumes	To evaluate the actions being taken by the Trust to ensure the health and wellbeing of staff exposed to fumes as a result of delays in handovers of care at hospital.
Patient Experience and Community Involvement	To provide assurance on compliance with the Health and Social Care Quality Engagement Act and alignment with the Trust's IMTP.
Rollout of Pentrox	To assess the impact of the rollout of Pentrox on patients and staff, following the recent announcement that it can be administered by ambulance crews and Community First Responders.

Review Title	Objective
Overtime Controls	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.
Emergency Nurse Communications System (ECNS) Implementation	To provide assurance that benefits realised reflect those identified at the outset of the system's implementation.
Data Quality	To review the structures and processes for ensuring data quality and accurate reporting within the Trust.
Occupational Health and Wellbeing Support	To evaluate the programmes in place at the Welsh Ambulance Services University NHS Trust (the Trust) to improve the Occupational Health and Wellbeing services and promote staff wellbeing, and the arrangements in place to monitor effectiveness.
Speaking Up Safely	To review the implementation of the framework and assess its impact in promoting a culture that enables staff to raise concerns.
Capital Systems	These audits review the control framework, systems and processes in place to manage discretionary, EFAB or other capital / estates funded schemes – ensuring compliance with minimum requirements.

5.4 Limited Assurance (Amber)



In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Vehicle Accident Management	To assess the management of accidents relating to Trust vehicles, and the mitigating actions being taken to reduce the rate of occurrence.
Start of Shift Procedure	To assess compliance with the Start of Shift procedure, including the preparation of vehicles and to ensure that key equipment and medicines are available.

Review Title	Objective
111 Wales Website (draft)	To assess whether the 111 Wales website enables secure and effective provision of patient services.
Resourcing Policy	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.

5.5 Unsatisfactory (Red)



No reviews were assigned an 'unsatisfactory' opinion.

5.6 Advisory/Assurance Not Applied (Grey)



The following review was undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for this review is deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate, but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Contract Management	To assess whether the Trust has appropriate contract management arrangements in place.

6. Acknowledgement

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Trust to support delivery of the Internal Audit assignments undertaken within the 2024/25 plan.

Osian Lloyd

Pennaeth Archwilio Mewnol/Head of Internal Audit

Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services

Partneriaeth Cydwasaethau GIG Cymru/NHS Wales Shared Services Partnership

June 2025

Appendix A Conformance with Internal Audit Standards

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing Orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit, Risk and Assurance Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit, Risk and Assurance Committee Chair. There have been no impairments to our independence during 2024/25.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. An EQA was undertaken in 2023.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit, Risk and Assurance Committee.

	Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk-based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit, Risk and Assurance Committee. An annual report and opinion is produced for the Audit, Risk and Assurance Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit, Risk and Assurance Committee. In addition, audit reports are followed up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management, it would be discussed and will be escalated to Board level for resolution.

Appendix B Audit Assurance Ratings

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	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.

Disclaimer

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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.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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 management of the Welsh Ambulance Services University 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.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)



Follow Up Review

Final Internal Audit Report

2024/25

Welsh Ambulance Services University NHS Trust



Reasonable Assurance

Contents

Executive Summary 1

At a glance.....2

Progress with Prior Year Recommendations 4

Appendix A Assurance Opinion & Prioritisation of Findings 13

Review Reference	WAS-2425-02
Fieldwork	February – May 2025
Executive Sign Off	3 June 2025
Audit Committee	24 June 2025
Executive Lead	Trish Mills, Director of Corporate Governance
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit



Executive Summary

Purpose

To provide assurance on the status of implemented recommendations on the audit tracker and review the systems and arrangements the Trust has in place to monitor progress with the implementation of actions.

Overview

The arrangements in place within the Trust to track progress in relation to audit findings remain effective, including scrutiny by the Corporate Governance team and the Assistant Director Leadership Team (ADLT) prior to the closure of actions on the tracker. Board Committee receive audit reports in line with their remit, and monitor management actions to address recommendations. The Audit, Risk and Assurance Committee (ARAC) also scrutinises the progress of audits recommendations overall, escalating to the Board any issues or concerns.

The quarter three tracker report highlighted continued good engagement with Directorates, which resulted in 27% open internal audit actions being closed in quarter. The report also indicated that some audit actions have been delayed because of seasonal pressures, and noted that a significant number (60%) of the actions are due for closure in Quarter 4 of 2024/25. We were subsequently advised by management, at the date of fieldwork closure, that 72% of the actions due in quarter four were closed in that period; which represented 51% of the total internal audit actions. We note that Audit Wales' recent Follow-up Review of Quality Governance Arrangements (September 2024) identified that several actions had been closed on the tracker which they considered to be ongoing. They recognised that the Trust has responded to this and is considering ways to encourage clearer commitments to actions within management responses to recommendations.

Our testing confirmed that 18 of the 18 recommendations tested at this review were appropriately classified as complete on the tracker. It is noted, however, that there were a number of instances where the initial documentation provided to support recommendation closure was not sufficient, with further evidence needing to be requested. We also note that whilst actions are closed, further work is planned to mitigate the risks previously identified to an acceptable level.

The Trust is in the process of testing the new tracker system that has been developed with support from Digital Health and Care Wales (DHCW), with implementation planned early in the 2025/26 financial year. Reporting on the new tracker will be generated by Power BI and, going forward, ARAC will identify actions within audits to improve the scrutiny of their impact.

A tracker has recently been developed to capture Counter Fraud actions, which addresses a recommendation raised in our 2022/23 follow up report. We were informed will be presented to the closed session of the ARAC from May 2025 onwards.

At a glance

We undertook a follow up review of the two limited assurance internal audit reports issued during 2023/24, to provide assurance that the Trust has implemented a sample of the related recommendations appropriately and in a timely manner. We have also considered a sample of high priority recommendations from reasonable assurance reports and reviewed the systems and arrangements the Trust has in place to monitor progress with the implementation of actions.

The scope of this follow-up review does not provide assurance against the full scope and objectives of the original audits or that the matters arising to which they relate have been fully closed. The follow-up review opinion provides assurance against the level of implementation of the recommendations reviewed only.

The following table sets out the sample of closed recommendations selected from the tracker (as at end of Q3 – October to December 2024) ¹:

As per original Internal Audit Report				As per tracker	
Report title	Assurance rating	Matters arising raised	Number of recommendations	Number of management actions in the tracker	Total reported closed
Decarbonisation	Limited	4	6	6	5 – remaining action not yet due.
Estates Condition	Limited	9	12	12	12
Trade Union Release Time	Limited (2022/23)	4	4	9	7
Seatbelt Action Plan	Reasonable	4	6	6	6
Records Management	Reasonable	6	7	10	6
Disciplinary Case Management	Reasonable	6	13	14	10
Vehicle Replacement Programme	Reasonable	6	9	9	8

¹ The quarter three tracker update reported that the high priority matter arising (MA2) relating to the ePCR Clinical Compliance reasonable assurance report (original timescale September 2024) had not been addressed in full and remained open, therefore testing was not undertaken. At the date of reporting, we note that four of the seven management actions remain open and are now all overdue.

Our analysis of the Trust’s quarter three tracker report to ARAC highlights that 67.9% of all internal audit recommendations raised since 2022/23 are recorded as closed (All Wales average: 65.1%), 17.6% are not yet due (All Wales average: 18.1%), with the remaining 14.4% overdue (All Wales average: 16.1%).

Corporate approach to tracking recommendations

As previously reported, the Trust has effective arrangements to monitor progress in relation to the implementation of recommendations. The audit tracker is maintained by the Corporate Governance Team. The Team receives all audit reports (both internal and external) for inclusion in Committee papers which ensures that the recommendations tracker captures all recommendations raised, including those from Healthcare Inspectorate Wales (HIW).

The Team have produced the ‘Audit Process and Reporting Handbook’, which contains a section on the audit tracker and sets out the cycle of review and responsibilities for associated actions. The handbook details that Directorates are expected to review and update the tracker on a monthly basis, so that there is continuous monitoring of progress against the actions. The tracker is received by the Assistant Directors Leadership Team (ADLT) to facilitate a ‘check and challenge’ following Directorate updates (which we were informed have also been subject to a separate ‘check and challenge’ by the Head of Compliance &

Assurance to confirm robustness of evidence provided to support closure); and to escalate where they have not been provided. The Corporate Governance Team also undertake a formal quarterly review of the tracker and will examine the evidence provided to support closure of an action, before reporting updates to Committees.

Board Committee receive audit reports in line with their remit, and monitor management actions to address recommendations. The Audit, Risk and Assurance Committee (ARAC) also scrutinises the progress of audits recommendations overall, escalating to the Board any issues or concerns. Responsible Directors appeared at the November 2024 ARAC meeting to discuss the open actions that are on their third and final revised date, including the rationale the movement of these dates and any residual risks.

The quarter three tracker report highlighted continued good engagement with Directorates, which resulted in 27% open internal audit actions being closed in quarter, down from the 37%. The report also indicated that some audit actions have been delayed because of seasonal pressures, and noted that a significant number (60%) of the actions are due for closure in Quarter 4 of 2024/25.

Audit Wales' Structured Assessment 2024 (issued November 2024) reported that the Trust was strengthening its systems for tracking responses to audit recommendations. However, it did state that *"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. The Trust has responded to this and is considering ways to encourage clearer commitments to actions within management responses to recommendations."*

The Trust is in the process of testing the new tracker system, with implementation planned early in the 2025/26 financial year. The new version will be a SharePoint solution, and its development has been supported by Digital Health and Care Wales (DHCW). It has been agreed that the new tracker will include actions from 2025/26 onwards, the current Excel tracker will continue to capture actions prior to that. Reporting on the new tracker will be generated by Power BI, and ARAC has recently reconfirmed the metrics that will be captured to enhance oversight and scrutiny. Going forward, ARAC also agreed to identify actions within audits to improve the scrutiny of their impact.

In our 2022/23 follow up report we recommended that the Trust should consider the inclusion of recommendations from other assurance providers within the tracker e.g., Counter Fraud. A tracker has recently been developed to capture Counter Fraud actions, which we were informed will be presented to the closed session of the ARAC from May 2025 onwards.

Progress with Prior Year Recommendations

Decarbonisation: Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
1.1	Decarbonisation Programme Board: Attendance The named membership in the terms of reference should be reviewed again to ensure reasonable and appropriate representation at the Decarbonisation Programme Board (DPB).	Decarbonisation Project Manager and Head of Capital Development 30 April 2024	Medium	Closed On completion of the internal audit, the DPB reviewed the Terms of Reference in place, including the membership for the project board. The project board agreed that the current membership was deemed appropriate. A review of the previous four project board meetings was undertaken, this determined that attendance had improved from the original review.
2.1	Delivery of the Decarbonisation Action Plan Challenges and risks to the achievement of the objectives within the Trust's Decarbonisation Action Plan (DAP), along with any mitigating factors, should continue to be monitored with regular updates provided via the established governance routes through to Trust Board.	Head of Capital Development. N/A – Action considered closed.	High	Closed Regular reporting on the DAP and risk register has also continued to feature to DPB, Capital Management Board, Finance and Performance Committee and Trust Board.

Estates Condition: Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
6.1	Delivery - reporting 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.	Assistant Director of Capital & Estates 30 June 2024	Medium	Closed Backlog maintenance has been reported through the Finance & Performance Committee annually in line with the Estates and Facilities Performance Management System (EFPMS) submission.
8.1	Risk reporting 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.	Assistant Director of Capital & Estates 31 March 2024	Medium	Closed Post the completion of the audit, we note that the risk profile of the estate has changed therefore are comfortable that the recommendation is reported as closed. Whilst not a specific action from the audit, we can take assurance that the Trust is looking to review its Estate to reassess condition and reevaluate the assigned risk in the upcoming year.

Trade Union Release Time: Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
Facilities agreement				
1.1a	In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust. <u>Note:</u> <i>In the context of the ongoing industrial action at the time the report was issued, the Trust was not in a position to revisit the agreement in the short-term but would revisit at a point in the future in the context of resetting the relationship with Trade Union (TU) partners after the industrial action issues are resolved.</i> <i>The recommendation was noted but not accepted per se based on the relationship with TU partners at the time. The management response noted the actions committed.</i>	Deputy Director of Workforce & OD 31 March 2024 Internal conversation on whether full time representatives are appointed	High	Closed Regarding the wider recommendation to revisit the Facilities Agreement, the Trust does not intend to do this as we were informed that the Agreement is working for the organisation. We were advised that the recent Social Partnership legislation puts a duty on the organisation to consult and engage more widely rather than reducing or introducing further controls. TU partners are clear that it is their responsibility to maintain accurate records of their TU duty time which can be requested by the organisation. In the spirit of partnership working, relationships are based on trust and responsibility. Work on an electronic timesheet continues and this may be the long-term solution, alongside the replacement to ESR. In addition, quarterly reports are being produced from Finance and Resources respectively to track activity, although we note that these are not formally reported and monitored within the Trust.
1.1b		Deputy Director of Workforce & OD 31 March 2024 Broader discussion with TU reps regarding maintenance and development of clinical		Closed It was recognised during the previous audit that there were a handful of senior representatives who had not undertaken clinical duties for some time as a result of the length of time they spend on TU activities.

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
		skills whilst undertaking TU duties		We were informed that discussions between the with key TU partners have been held by the Trust, which confirmed that the vast majority of TU reps undertake shifts in their substantive posts. TU partners recognise the importance of this in terms of having authenticity with their members and understanding their roles. Where a TU rep is not undertaking active duties there is justification for this and it is being managed on a case basis.
1.1c		Deputy Director of Workforce & OD Ongoing Regular discussions with senior TU reps in WAST re time for TU duties, trends and peaks in activity	High	Closed We were informed that conversations have been held about the wellbeing of TU partners who undertake significant work in addition to their contracted working hours in their substantive posts. Although we note again that this is not being done formally, rather through conversations in a variety of settings and one to one discussions. Examples of discretionary effort has been shared (where time has not been claimed). The Trust manages attendance at Committee meetings, project groups etc. by having nominated representatives at meetings.

Seatbelt Action Plan: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
Monitoring of Health and Safety Investigation recommendations and assurance reporting to Board				
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.	Assistant Director of Operations, Ambulance Care May 2024	High	Closed The ADLT have resumed responsibility for the monitoring and implementation of the 11 recommendations identified from the Health & Safety investigation. A review of the ADLT work programme noted that the H&S Investigation is a standing item with the latest meeting (28 April 2025) providing the status update as two actions outstanding with plans in place to address.
4.2	Should a similar serious incident occur in the future, assurance on the progress made by the Trust to address identified actions and recommendations and the arrangements to embed and sustain safety practices and processes should be provided at Board and Committee level.	Closed	High	Closed The Trust accepted the recommendation on receipt of the final audit report, agreeing that if a similar incident was to occur in the future, assurance would be sought at the QuEST Committee within its closed sessions.

Records Management: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
Records Services & Archives (RSA) Team Resilience				
1.1	Management should ensure that a full review of current resources, how resource is used and time required to complete all legislative duties is undertaken, to identify gaps and risk areas upon which capacity and resilience can be measured.	Director of Digital December 2023	High	Closed A new risk has been created within the departments risk register capturing the consequences of limited capacity on Trust compliance with legislation. The is monitored at the weekly Health Informatics Senior Management Team meeting. As part of the Digital Plan refresh, the Trust has invested in and subsequently recruited additional Records Officers within the team, which is now fully resourced.
1.2a	The IG reports should include a measure of the complexity of requests.	Records Services & Archives Manager January 2024 – process mapping in respect of coroner requests	High	Closed Coroner requests were identified as a process possibly suitable for automation which would create additional capacity within the team. However, it was determined that this would not be appropriate at this stage.
1.2b		Assistant Director of Digital Services January 2024 – new metrics	High	Closed Complex cases, defined as requested that take over an hour to process, are monitored including by type, e.g. subject access requests, health and police, via the Information Governance highlight report which is presented at the Information Governance Steering Group (IGSG). We also note that there is intention to incorporate complex case data into the IGSG KPI report to enable trend analysis in future.

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
6.1	Retention and Destruction of Records The records management improvement plan noted in MA2 should include an assessment of the disposal of records (both physical and digital) and ensure that records are removed as appropriate.	Records Services & Archives Manager December 2023 – for Digital Notice	High	Closed The Records Management Improvement Plan includes an item for records disposal. However, after a period of demand and capacity challenges within the function we note that the Trust has reported slippage in implementation dates for actions. A review of timelines of the improvement plan has helped focus efforts on the highest priority areas. Additionally, records management training, including a topic on disposal, has been created and published on the Digital SharePoint site to increase awareness.

Disciplinary Case Management: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
Case Management Documentation				
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.	Deputy Head of People Services 31 July 2024	High	Closed The People Services Team has produced a 'Human Resource Checklist for Respect & Resolution and Appeal Hearing'. The checklist highlights the required documentation to be retained within the Respect & Resolution (R&R) pack, as well as the required documents for appeals.
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.	Deputy Head of People Services 31 July 2024	High	Closed The People Services Team has introduced an Employee Relation (ER) case file audit schedule, which sets out the intention to undertake bi-monthly checks on case files. The audits consist of reviewing ten case files to ensure adherence and completeness against the required documentation outlined in the newly introduced checklists. The audits commenced in August 2024 with the outcomes compiled into a word document. Audits have highlighted gaps and non-compliance across case files and ER tracker, which are continually raised with the team to highlight the importance of working within agreed processes.
5.3	Any revision to disciplinary toolkit template documentation should retain direction that completed copies should be shared with the People Services team.	Deputy Head of People Services 31 July 2024	High	Closed An email has been sent out to the team reminding that if any documentation in the manager's toolkit is amended or updated going forward then version control has to be used, alongside the reiteration that copies will be retained and shared within the People Services Team.

Vehicle Replacement Programme: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
Contracts				
5.1	Contracts should be discretely authorised in accordance with Standing Orders.	Executive Director of Finance & Corporate Services and Trust Board Secretary March 2024	High	Closed 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 was taken to and approved by the Trust Board in July 2024.
5.2	Pre-tender estimates and variance commentary should be utilised to inform tender evaluations	Head of Financial Business Intelligence & Capital Planning and National Fleet Manager At future business case compilation	Medium	Closed A note has been placed in the Finance and Performance Committee cycle of business to prompt a reminder to ensure pre-tender estimates and variance commentary is in the next business case (BJC) for the tender evaluation.

Appendix A Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	Follow up: all recommendations implemented and operating as expected.
	Reasonable	Follow up: all high priority recommendations implemented and progress on the medium and low priority recommendations.
	Limited	Follow up: no high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	Unsatisfactory	Follow up: no action taken to implement recommendations.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

AGENDA ITEM No	5.2.2
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

CONTRACT MANAGEMENT ADVISORY REPORT

MEETING	Audit, Risk and Assurance Committee
DATE	24 June 2025
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary Chris Turley, Executive Director of Finance and Corporate Resources
AUTHOR	Trish Mills, Director of Governance / Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. A review of Contract Management arrangements has been undertaken by Internal Audit as part of the 2024/25 IA plan. This has resulted in the Contract Management Advisory Report, and has been conducted at all NHS Wales health bodies, enabling a compare and contrast of all organisations to take place. No assurance rating has been applied to the report.
2. The scope of what was originally an internal audit review into contract management, enabled the Trust to undertake a review of contract management arrangement in place. This coincided with the Service Review which also sought to understand the contracts each directorate had in place. A task and finish group approach was applied with the support of the Assistant Directors Leadership Team (ADLT) to develop a register of contracts, and to identify where stand-alone registers and contract management arrangements are in place.
3. As indicated in the report, this is in its infancy. The intention of this exercise was not to develop a contract management system. The resources and digital solution to do so simply do not exist at this stage, and to redirect those resources was felt to be disproportionate to any risks that were identified.
4. Those areas of the organisation where there may be financial and reputational risks that flow from poor contract management processes do have more advanced arrangements. For example, the digital directorate has a supplier contract SOP which sets out expectations and process. The March 2024 ICT Contract Management Internal Audit assessed whether the Trust has appropriate contract management arrangements in place in this area and received reasonable assurance. Six of the seven recommendations of that audit were closed on their expected closure date, with one outstanding and due for closure in September. Additionally, it was noted that there is a central listing of capital contracts maintained by the Finance & Corporate Resources Directorate providing details of funding source, contract value, contractor, contract type and date of approval. ARAC

will note the Internal Audit on Capital Systems for 2024/25 has also received reasonable assurance.

5. Whilst this report indicates that there could be enhancements to the format and completeness of the overarching register developed to support this review, no further work is intended at this stage to maintain that register due to the resource implications thereof.
6. The exercise did however provide a good impetus for a closer review of requirements for each contract manager, and whilst any central actions are awaited as a result of the report, it is intended to develop a joint Siren Notice from the Finance and Corporate Resources (FinCoR) and the Corporate Governance Directorate. Noting that much of the NHS Wales procurement processes are centralised with NWSSP Procurement Services, this notice will serve as a reminder to directorates of:
 - Standing Financial Instructions sections on procurement (noting these have recently changed with the introduction of the Social Partnership and Procurement Act 2023, an update on which is due to be presented to the September ARAC meeting)
 - Relevant delegations in the Scheme of Reservation and Delegation
 - The need for an identified contract manager who has performance and financial oversight
 - Monitoring – potentially through developing and maintaining directorate contract registers
 - Reporting and escalation requirements
7. The Executive Director of FinCoR will continue to engage with NWSSP Procurement Services through the Directors of Finance Peer Group and by attendance at the NWSSP Partnership Committee, on actions within their purview. These include a proposed NWSSP Contract Management Procedure,
8. The actions set out in the advisory report did not require management actions, but for completeness and assurance, ARAC will note the following:

Action	Response
Action 1: Contract Management Procedures The Digital Directorate's Supplier Contract Management SOP provides a good basis for contract expectations, responsibilities and accountabilities; but recognising that some established good practice is now available from within the wider NHS, the Trust may wish to engage with NWSSP Procurement Services	As per paragraph 7, we will continue to engage with NWSSP. In the meantime, we will develop and communicate a Siren Notice as per paragraph 6. Siren Notice: 15 July 2025

in relation to implementation of the NWSSP Contract Management Procedure	
Action 2: Contracts register Complete the development of the Trust-wide contract register to record and manage contract records and information. The register in its current format provides a basis for the capture of contracts and the organisations contracting risks; however, there could be enhancements to provide a clearer picture of contract performance.	For the reasons set out above we will not be developing a centralised register. However, the Siren Notice will include a recommendation for a directorate based register.
Action 3: Training Needs Analysis A mechanism should be established to ensure senior managers identify any specific training requirements to support operational contract management – reflecting the capacity / capability of individuals and the requirements of the specific contracts.	It is recommended that more is known about the training provision in action 4 before a WAST training needs analysis is developed.
Action 4: Training Provision The Trust should engage with other NHS Wales organisations to develop contract management training, to ensure staff are equipped with the tools and skills to manage the key stages and lifespan of contracts	As per paragraph 7, we will continue to engage with NWSSP.
Action 5: Contract Ownership, Documentation and Management Our review of contract management arrangements within the Trust identified that not all individuals had been formally assigned responsibility for contract monitoring, with some having had no prior involvement within the tendering process, which could impact on the understanding of the expectations of the role.	The Siren Notice recommends that a contract manager is identified for each contract and that that is set out on the register.
Action 6: Reporting, Escalation and Risk Management Arrangements Expected internal monitoring / reporting arrangements should be	

defined at the outset of the contract – cognisant of the risk, value, complexity and strategic importance of the contract.	The Siren Notice emphasises the need for reporting and escalation mechanisms for contracts.
RECOMMENDATION 9. ARAC is requested to receive assurance on the actions being taken locally with respect to the Siren Notice for all staff, and to note the continued partnership working with NWSSP Procurement Services on centralised training and processes.	

KEY ISSUES/IMPLICATIONS
The key issues and implications are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
N/A

REPORT APPENDICES
N/A

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

Contract Management

Final Advisory Report

2024/25

Welsh Ambulance Services University NHS Trust

Contents

Executive Summary	1
Findings & Agreed Action Plan	3
Appendix A: Assurance Opinion & Prioritisation of Findings.....	9

Review Reference

WAST-2425-03

Fieldwork

February 2025 – May 2025

Executive Sign Off

4 June 2025

Audit Committee

24 June 2025

Executive Lead

Chris Turley, Director of Finance & Corporate Services; Trish Mills, Director of Corporate Governance

Audit Team

Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit



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Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Executive Summary

Purpose

The review assessed whether appropriate contract management arrangements were in place within the Trust. This review has been undertaken further to the Contract and Procurement advisory review at Betsi Cadwaladr University Health Board (BCUHB), completed at the request of Welsh Government in 2023/24, which identified several areas of concern and non-compliance with the organisation's Standing Financial Instructions. Through inclusion within NHS Wales organisations 2024/25 Internal Audit plans, this review has compared and contrasted the appropriateness of contract management arrangements across eight more organisations, with common issues and challenges noted.

An assurance rating has not been applied to this review, recognising the consistency of approach with the BCUHB review, and that actions raised will need to be taken forward in partnership with other NHS Wales organisations, including NWSSP Procurement Services. These actions, alongside those specific to the Trust, are aimed at improving and/or enhancing expected controls in contract management arrangements.

Overview

Noting the infancy of the Trust's contract register, for the purposes of this audit, sample testing was based on the Electronic Contract Management module of the Bravo e-tendering system. Contract selection was undertaken to ensure consistency with similar reviews undertaken at a number of NHS Wales organisations. All Wales Contracts were excluded from our sample; in addition to Capital and Estates contracts noting that separate Capital Systems reviews have been undertaken by our Specialist Services Unit (SSU) at a number of NHS organisations as part of the 2024/25 Internal Audit Plan – the coverage of which has also included contract management.

The following observations have been identified for management attention across all reviews completed:

- The need for consistent contract management procedures to support the requirements of the Standing Financial Instructions, this could be through engagement with NWSSP Procurement Services to adopt their Contract Management Procedure;
- Comprehensive contract registers were not in place. We note, however, that the Trust has made progress with the development of a contract register but this is at an early stage and there could be enhancements to its format and completeness;
- A mechanism to determine the capacity and support needed to meet existing and future contract monitoring requirements, with appropriate training provision;
- Responsibility for contract management should be formally assigned and accepted;
- Variations in the formality of contract management, performance reporting, and documentation, which indicates a level of inherent risk, and which could be addressed by increasing the robustness of the control environment; and
- The minimum internal reporting, accountability and escalation requirements should be considered and defined at the outset of contracts.

The Trust should ensure appropriate arrangements are in place to engage with wider NHS Wales organisations and NWSSP Procurement Services in developing a coordinated agreed action plan via the Directors of Finance forum, to address the common themes and issues identified within this and corresponding reports.

Full details of matters arising are detailed within the Findings & Agreed Actions.

Scope & Actions Summary

Objectives		Related Actions
1	There is a clear framework of policies, procedures and processes for contract management, with roles and responsibilities clearly defined.	1
2	Contract registers are used as the basis for effective contract management and procurement planning.	2
3	Contract managers have access to relevant training and development.	3, 4
4	Service levels/deliverables are specified in the contract, with standard terms and conditions applied, and are linked to service needs and monitored by the assigned contract manager/end user.	5
5	Contract performance and risk is reported and managed within the Trust’s governance structure.	6

Management Actions



Themes



Risk Types

- Public Perception & Reputational Risk
- Financial Loss
- Quality or Safety Issues
- Legal & Regulatory Non-Compliance

Findings & Agreed Actions

Objective 1: There is a clear framework of policies, procedures and processes for contract management, with roles and responsibilities clearly defined.

The Trust's Standing Financial Instructions (SFIs) includes a section on contract management. Section 11.16.1 outlines that the relevant budget holder is responsible for overseeing and managing each contract on behalf of the Trust to ensure that implicit obligations are met. This includes:

- *Retaining accurate records;*
- *Monitoring contract performance measures;*
- *Engaging suppliers to ensure performance delivery;*
- *Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and*
- *Permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.*

In addition to the above, there is an All-Wales Procurement e-manual, which contains high-level contract management guidance, available via the Trust 'Oracle' system home page. In discussion with staff, this document is not a regular point of reference.

The Digital Directorate within the Trust has a Standard Operating Procedure 'Supplier Contract Management' (the Digital SOP). This provides the basis for a standardised approach through the definition of contract management roles and responsibilities across the lifespan of a contract; and outlines the factors to consider in assigning each contract a priority level (high/medium/low), with each level having corresponding contract management and monitoring requirements. Following its approval in January 2024, implementation of the Digital SOP is progressing, and we noted the intention to engage with contract managers outside of the Digital Directorate as the next stage in its development. Review of other NHS organisations indicated that the majority did not have local contract management guidance in place, an exception was noted for Aneurin Bevan University Health Board where, in conjunction with local NWSSP Procurement, there has been the development of a Contract Management Financial Control Procedure (FCP). The FCP outlines roles and responsibilities for contract management, requiring designated contract managers to complete standardised 'Contract Management Plans' for contracts over £100,000 in value. Wider dissemination of the content from the FCP was discussed at the NWSSP Heads of Procurement meeting in February 2025, and there was support for its further roll out across other NHS Wales organisations.

The above could inform the basis for a Trust wide guidance document, with consideration of enhancements identified from good practice elsewhere through supportive template documentation, expected reporting and escalation arrangements, and integration with the Trust's risk management framework to provide robustness for wider use across the organisation (see **Action 1**).

Action 1: Contract Management Procedures

The Digital Directorate's *Supplier Contract Management SOP* provides a good basis for contract expectations, responsibilities and accountabilities; but recognising that some established good practice is now available from within the wider NHS, the Trust may wish to engage with NWSSP Procurement Services in relation to implementation of the NWSSP Contract Management Procedure.

Objective 2: Contract registers are used as the basis for effective contract management and procurement planning.

A contract register is important as it provides:

- Contract Tracking: to track important dates, such as start and end dates, renewal periods, and milestones associated with each contract.
- Compliance and Risk Management: to ensure that the organisation stays compliant with contract terms and legal requirements, and to help identify any potential risks by keeping a record of contract clauses, obligations, and renewal terms.
- Audit Trail: provided for each contract, including amendments and performance evaluations. This makes it easier to track changes and decisions related to a contract.
- Centralised Repository: allowing easier access for teams like legal, procurement, and finance when they need to refer to specific terms, obligations, or other contract details.
- Improved Communication: enhances communication across departments, as everyone involved can refer to the register to ensure that they are aware of their obligations and responsibilities under various contracts.
- Budget and Financial Tracking: for financial management to track contract values, payment terms and other financial aspects to ensure proper budgeting and forecasting.

The Social Partnership and Public Procurement (Wales) Act 2023 includes that a contracting authority must create, maintain, and publish a contract register. Reliance has previously been placed on information held in the Electronic Contract Management module of the Bravo e-Tendering system which sample testing, see *objective 4*, has highlighted this is not a reliable source with incomplete and/or out of date information. However, we note that the Trust is currently developing a central list of contracts through engagement with the Assistant Director Leadership Team (ADLT). A copy of the draft Trust contract register was shared with us, noting its status as in-progress. Management has advised that further resources and digital support would be required to complete and maintain.

It is positive to note the inclusion, within the Trust's register, of procurement route, governance, legal and regulatory aspects, which would offer a clearer view of the Trust's contract management arrangements. We note the opportunity to align with the contract categorisation identified within the Digital SOP (see *objective 1*); and whilst there is a column for key performance indicators, there could be more detail relating to the contracts' performance status and any escalation required (see **Action 2**).

Within our sampled contracts (see *objective 4*), only one contract manager indicated a directorate contract register was in place - an ICT contract register within the Digital Directorate. This includes Contract title; supplier; value; department; Trust lead, procurement process used and start and end dates, however the details held within the directorate register were yet to be transferred to the Trust wide register (see **Action 2**).

We acknowledge that a central listing of capital contracts is also maintained by the Finance Directorate (this provides details of funding source, contract value, contractor, contract type and date of approval) and note that the details of such have also yet to be transferred to the Trust wide register. No further review of capital contracts was undertaken noting the separate Capital Systems audit being undertaken (for which Reasonable Assurance has been determined).

Action 2: Contracts register

Complete the development of the Trust-wide contract register to record and manage contract records and information.

The register in its current format provides a basis for the capture of contracts and the organisations contracting risks; however, there could be enhancements to provide a clearer picture of contract performance.

Objective 3: Contract managers have access to relevant training and development.

This audit, and similar reviews at other NHS Wales Organisations, observed that contract management was undertaken by combination of:

- Dedicated contract managers;
- To fulfil an existing element of a job description / role; and
- As an unspecified additional responsibility.

The demands on staff was dependent on the specific performance monitoring requirements of the contract and varied significantly.

For the sampled contracts, there was no evidence of an assessment of the capacity / capability requirements to fulfil the role and / or the identification of any training requirements to address any gaps (see **Action 3**). Similarly, no specific contract monitoring training had been provided, although within our sample (see *objective 4*), all but one (5/6) had a reference to contract management within their job description (noting that two were managed by the same individual).

The Trust's SFIs include within Section 11.16.3 that 'Advice on best practice on Contract Management is available from NWSSP Procurement Services.' As per objective one, staff contacted through fieldwork did not have awareness of the NWSSP Procurement e-Manual, which contains contract management guidance (see **Action 4**).

Action 3: Training Needs Analysis

A mechanism should be established to ensure senior managers identify any specific training requirements to support operational contract management – reflecting the capacity / capability of individuals and the requirements of the specific contracts.

Action 4: Training provision

The Trust should engage with other NHS Wales organisations to develop contract management training, to ensure staff are equipped with the tools and skills to manage the key stages and lifespan of contracts.

Objective 4: Service levels/deliverables are specified in the contract, with standard terms and conditions applied, and are linked to service needs and monitored by the assigned contract manager/end user.

Standing Financial Instructions (11.6.1) require that *"The relevant budget holder, shall oversee and manage each contract on behalf of the Trust so as to ensure that these implicit obligations are met."*

A sample of six contracts were selected from the contract management module of the Bravo e-tendering system, and this was undertaken in conjunction with reviews taking place at other NHS Wales organisations to provide consistency of service/contract type where possible. Common themes across these reviews have been identified which will need a consistent approach to be addressed on an All-Wales basis, in conjunction with NWSSP's Procurement Services.

Evidence from Trust contract managers demonstrated ongoing contract management and operational understanding of the requirements of such, where exceptions have been identified below these were accompanied by mitigations.

Through discussion with contract managers and review of documentation we identified the following:

Designated responsible officer/contract ownership - Whilst the audit was directed to certain individuals for the sampled contracts for the audit, not all individuals had been formally assigned responsibility for contract monitoring - with some having had no prior involvement within the tendering process, which could impact on the understanding of the expectations of the role (see **Action 6**). Within our sample of contract managers, we identified one individual who performed a dedicated contract management role. Further, three of the six contract managers were not the individuals/contract leads listed within the Bravo e-tendering system report (GCloud, Employee Assistance Programme, Tail Lift Repairs and Servicing, and Windscreen and Bodyglass replacement (the latter two managed by the same individual)).

The recording of the Senior Responsible Officer and budget holder within contract documentation varied in the documentation reviewed, and this, alongside the differences in the contract leads recorded within Bravo, indicates a need for the Trust to progress its own contract register, and ensure this is updated to reflect changes in ownership (see **Action 2**).

Contract documentation - Final signed contracts were not available for two of our sample contracts (Tail Lift Repairs and Servicing, and Windscreen and Bodyglass replacement). Trust managers noted that these had not been provided by NWSSP Procurement Services, but prior to audit fieldwork had not identified this gap (see **Action 5**). We note that specifications were available which had been utilised in awarding contracts through the tendering process to demonstrate the contract criteria, however the completeness of contractual terms and conditions had not been addressed.

Contract deliverables/performance measures - Review of contract documentation established that agreed and defined service deliverables were in place for four out of the six contracts tested. For the two exceptions, technical assessments and pricing comparisons respectively, formed part of the tender and award process and these were used as the basis for ongoing management. Contracts included detailed criteria for services or goods to be provided alongside associated key performance indicators and ongoing contract management arrangements, however these were not available for those contracts without final documents. (see **Action 5**)

Contract management/monitoring - The formality of monitoring arrangements within our sample reflected the differences in their value and business criticality, and this varied with weekly, monthly, and annual arrangements noted. We found that reporting received from providers was broadly in line with that specified within contracts, with one exception noted for the Employee Assistance Programme (see **Action 5**), where review of required and supplementary KPIs identified no concerns in the service provided. We identified an ICT contract not being monitored in line with the requirements set out within the Digital SOP and we noted enhancements could be made to capture where monitoring arrangements are of an informal nature, currently within two other contracts (see **Action 5**).

Action 5: Contract Ownership, Documentation and Management

Our review of contract management arrangements within the Trust identified that not all individuals had been formally assigned responsibility for contract monitoring, with some having had no prior involvement within the tendering process, which could impact on the understanding of the expectations of the role.

Further we identified the following issues from our testing of a sample of six contracts:

- We could not evidence final contract documents in place for Tail Lift Repairs and Servicing, and Windowscreen and Bodyglass replacement.
- For Tail Lift Repairs and Servicing, and Windowscreen and Bodyglass replacement contracts we note that regular informal discussions with suppliers are held, but records of issues or follow up actions are not maintained to demonstrate ongoing contract management.
- The ICT contract for Nutanix hardware and software had no reporting or monitoring arrangements in place. However, based upon the Digital SOP the contract should be classed as medium priority (suggested monitoring - annual review). Discussion with the contract manager indicated there had been no issues or further support required to date.
- Three out of nine KPIs for service delivery listed within the Employee Assistance Programme specification were not within provider reports;
 - All calls answered within 2 minutes (including time on hold).
 - All cases requiring formal therapy to begin sessions within 3 weeks.
 - All cases requiring legal or financial advice to beginning receiving advice within one week.

Noting the above, the Trust should ensure contract managers are aware of their responsibilities as required by the SFIs. This should reiterate the need to retain full and accurate records in support of contract ownership, contract documentation, and monitoring of contract performance.

Objective 5: Contract performance and risk is reported and managed within the Trust's governance structure.

The SFIs relating to contract management (section 11.6) do not provide information on the expected minimum reporting, accountability and escalation arrangements in relation to contracts.

Our review observed varying approaches to monitoring arrangements, with most individuals with responsibility for contract monitoring outlining that escalation reporting was exception based; however, the reporting routes for escalation were not clear for all contracts within our sample with no criteria to guide circumstances where this should occur. For example, we noted an issue with the contract with Gcloud where delayed contract delivery could have been raised, however we also note that the issue had been resolved by the date of close of our fieldwork. It is important that the Trust defines the expected internal monitoring / reporting arrangements at the outset of the contract – cognisant of the risk, value, complexity and strategic importance of the contract (see **Action 6**).

Action 6: Reporting, Escalation and Risk Management Arrangements

Expected internal monitoring / reporting arrangements should be defined at the outset of the contract – cognisant of the risk, value, complexity and strategic importance of the contract.

Minimum requirements could be defined within the contract management procedure (see **Action 1**), with any divergence subject to appropriate approval.

Discussion with contract managers confirmed that they were aware of operational risks related to non-delivery of contracts, however we did not identify formal risk management practices relating to contract risk.

We are, however, cognisant of the manner in which the Trust can adapt its governance framework where a change in direction is required i.e. implementation of SALUS with the update on status, and subsequent action, reported through the IMTP delivery reports to the Finance & Performance Committee and the Trust board.

The Trust's Audit, Risk and Assurance Committee receives an update on procurement activity at each closed in-committee session. This includes the number of in-process and awarded contracts, alongside the number of times SFIs have been waived with explanatory notes to support their use. This overview does not extend to the ongoing management of contracts, nor any retrospective file notes where contract extensions have taken place without procurement support, which is a feature of reporting seen at other NHS organisations. In developing a Trust contract register, there will be the ability to provide regular assurance that contracts are managed appropriately, with exceptions identified and proportionate actions undertaken where required.

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)



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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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 management of the Welsh Ambulance Services University 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.

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Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Forecasting & Modelling

Final Internal Audit Report

2024/25

Welsh Ambulance Services University NHS Trust



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	4
Appendix A: Assurance Opinion & Prioritisation of Findings.....	13

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

WAS-2425-06

March - April 2025

27 May 2025

26 June 2025

Rachel Marsh, Executive Director of Strategy,
Planning & Performance

Osian Lloyd, Head of Internal Audit; Felicity
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Executive Summary

Purpose

To assess the Welsh Ambulance Services University NHS Trust's (the Trust) approach to forecasting and modelling, including focus on winter resilience planning.

Overview

The Trust set up a Forecasting & Modelling Group as part of their response to the Covid-19 pandemic. This became a permanent group co-ordinating forecasting and modelling activities across the Trust, in collaboration with the NHS Executive and the NHS Wales Joint Commissioning Committee (JCC). Arrangements have become business as usual for the Trust in undertaking strategic, tactical and operational forecasting and modelling to assist with service delivery, including on a seasonal basis such as winter resilience, and across NHS 111 Wales, Emergency Medical Services and Ambulance Care. An independent strategic Emergency Medical Services Demand and Capacity review is conducted every five years to identify the most efficient and effective way of meeting patient demand.

We have concluded **reasonable** assurance on this area. The matters requiring management attention include:

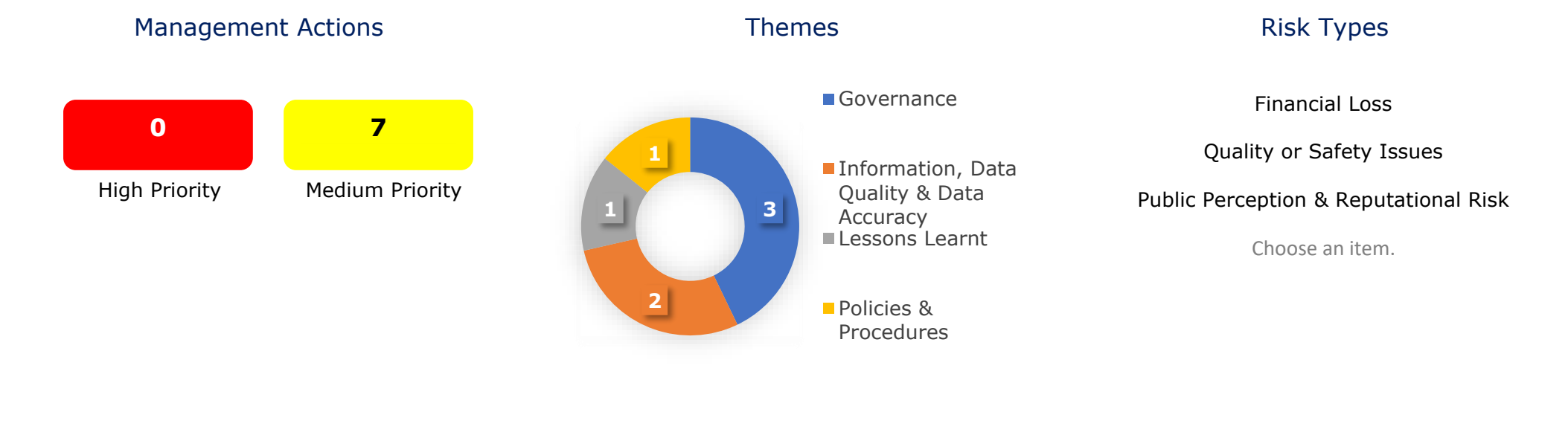
- To enhance the effectiveness of the forecasting and modelling process, there needs to be documentation to encompass key elements such as ownership, evaluation, approvals and quality assurance. There has been no comprehensive assessment to identify any gaps in forecasting and modelling activity in relation to the Trust's IMTP priorities.
- Roles and responsibilities for forecasting and modelling activities, and the key processes for undertaking such have not been documented. Staff business continuity arrangements would benefit from a review to ensure they are robust and enhance resilience.
- The content of the terms of reference for the Forecast and Modelling Group needs to be reviewed along with strengthening the administration of meetings.
- Whilst extensive analysis was undertaken as part of the last winter resilience planning, the effectiveness of the process could be strengthened by analysing actual performance against forecasted and modelled output. However, we note that actual performance is impacted by factors outside the Trust's control e.g. handover delays associated with wider system pressures.
- Review of the governance structure to ensure there is sufficient oversight of forecasting and modelling arrangements and appropriate escalation of key issues.
- Establishment of a robust mechanism to capture organisational learning arising from forecasting and modelling activities.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- There is no mechanism in place to confirm that the agreed actions contained within the winter plan have been addressed. We recognise that the plan was broadly representative of the Clinical Model Transformation plan and there is a clearer link to the Trust's IMTP priorities so performance can be tracked. However, there needs to be an appropriate level of oversight to ensure that any issues are addressed, e.g. enhancement to the accuracy of predicted performance for the next winter period.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	The Trust has appropriate arrangements and frameworks in place to coordinate forecasting and modelling activities that support strategic, tactical and operational decisions.	1,2,3	Limited
2	The forecasting and modelling process, tools and techniques have been applied appropriately for the winter resilience planning.	1,2,4,5,6,7	Reasonable
3	An appropriate governance framework is in place to provide effective oversight, monitoring and scrutiny of forecasting and modelling arrangements, and there are opportunities for continuous improvement and learning.	5,6,7	Reasonable



Winter Resilience Planning - At a Glance

The table below details the output results for the Most Likely Scenario (MLS) and Reasonable Worst-Case Scenario (RWC) for the winter period, which has been extracted from the Trust's Quarterly Forecast for Winter 2024/25:

Winter Period	Scenario	RED (%) <8mins	AMBER 1 Median	AMBER 2 Median	Abandoned Demand (%)
<i>Feb-23</i>	<i>BASELINE</i>	<i>51%</i>	<i>55min</i>	<i>1hr 16min</i>	<i>0%</i>
OctNov	MLS	47%	2hr 10min	4hr 0min	1%
OctNov	RWC	40%	5hr 35min	8hr 23min	5%
DecJan1	MLS	42%	4hr 3min	6hr 15min	3%
DecJan1	RWC	36%	8hr 36min	10hr 31min	8%
Jan234Feb	MLS	53%	1hr 13min	1hr 56min	0%
Jan234Feb	RWC	44%	3hr 11min	5hr 25min	2%
Mar	MLS	49%	1hr 58min	3hr 27min	1%
Mar	RWC	41%	5hr 11min	8hr 0min	4%

The table below categorises the Quarterly Forecast for Winter 2024/25 report's outcomes:

Scenario	Good	Not so good	Poor	Very Poor
RED Performance (%)	>= 65%	60% - 65%	55% - 60%	< 55%
AMBER 1 Median Response Time (mm:ss)	< 30min	30 - 45 min	45 - 60 min	>= 60 min
AMBER 2 Median Response Time (mm:ss)	< 60min	60 - 90 min	90 - 120 min	>= 120 min
Abandoned Calls	< 0.5%	0.5% - 1%	1% - 5%	> 5%

Findings & Agreed Action Plan

Objective 1: The Trust's arrangements and frameworks in place to coordinate forecasting and modelling activities.

Limited

Forecasting and modelling activities are embedded within the Trust in informing strategic decision-making across various services, including 111, Emergency Medical Services (EMS) and Ambulance Care, through the Demand and Capacity reviews being conducted every five years to ascertain the most efficient and effective way for meeting patient demand. Seasonal modelling is employed at a tactical level to prepare for the winter plan, while operational forecasting and modelling is carried out for key dates such as Easter. Forecasting is an integral part of the weekly review of REAP (Resource Escalation Action Plan). However, there is no mechanism in place to record the business-critical models or forecasts utilised by the Trust, or that plots key elements of the process (see **Key Finding 1**).

There is a small team responsible for carrying out forecasting and modelling activity consisting of two employees. One of the key responsibilities of the Forecasting and Modelling Group (as outlined in their terms of reference) was to develop and maintain a Framework, but this has been de-prioritised due to limited staff capacity and other priorities. However, there is no documented guidance, procedure or templates to establish consistency within the process, clarify roles and responsibilities, and provide robust business continuity arrangements (see **Key Finding 2**). The HM Treasury's '*Aqua Book: guidance on producing quality analysis for government*' could be used in the interim.

A Forecasting and Modelling Group was established as part of the Trust's response to the Covid-19 pandemic, which includes representation from the NHS Wales Joint Commissioning Committee (JCC), NHS Executive and Omda (external consultants - formerly known as Optima). While the Group's terms of reference provided key details relating to its purpose, quorum, meeting frequency, and reporting arrangements, the content could be enhanced to confirm its current membership and role as well as escalation arrangements (see **Key Finding 3**).

The Trust works with the NHS Wales Modelling Collaborative on a national basis, facilitating the exchange of good practice. We note that forecasting and modelling work has also been undertaken as part of service transformation (Omda Readiness software was utilised to assist with improving shift overruns).

Although risks associated with forecasting and modelling activities are not routinely documented, there is a risk recorded on the Strategy, Planning & Performance Directorate's risk register that has been recently reviewed, "*Failure to undertake forecasting and modelling, which means that the Trust fails to forward plan and mitigate demand & capacity changes at a strategic, tactical and operational level across 111, 999 and Ambulance Care, which impacts on patient safety and staff well-being*". Mitigations include the use of external experts for undertaking this work as part of contingency arrangements, but note that a formal Standard Operating Procedure (SOP) is required (see **Key Finding 2**).

Key Findings		Risk & Impact	Agreed Management Action
1	Modelling and Forecasting Process Through discussion, it is evident that while forecasting and modelling activity is clearly embedded within the Trust, the process lacks sufficient documentation and clarity of the arrangements. The following weaknesses were identified: - There is no mechanism that captures the business-critical models or forecasts that the Trust applies, to clarify ownership and track key stages of the process, e.g. approvals, evaluation undertaken, version control, etc. We note that the winter plan was discussed at Operations Directorate Senior Leadership Team meeting, but there is no record of its approval. - The work of the external consultants engaged for forecasting and modelling activities is subject to their own internal checks. The quality assurance reviews of the work performed within the Trust have only recently been initiated but cannot be consistently evidenced (we saw evidence within the EMS Operational Transformation Closure report). - One of the key responsibilities of the Forecasting and Modelling Group (as detailed in its terms of reference) is to obtain user feedback, but this is not clearly recorded within the process (although evidence was supplied of this for the Easter 2025 111 rostering). - There has been no comprehensive assessment or evaluation of the Trust's forecasting and modelling activities, including its alignment to key priorities. This would be beneficial for effectively managing staff resource and ensuring alignment with organisational goals.	Ineffective arrangements resulting in wasted resources and a failure to plan effectively resulting in poorly designed services.	Agreed Action: Complete the draft Standard Operating Procedure for Forecasting & Modelling. This would include approvals, version control and evaluations. Develop a forecasting & modelling report tracker, which would enable the Forecasting & Modelling Group to track where reports go, who uses them, user feedback, lessons learnt and benefits; and evidence of quality assurance (where appropriate). The Forecasting & Modelling Group will undertake a formal review of the draft IMTP from a forecasting and modelling perspective to ensure that its work programme reflects the IMTP priorities.
			Expected Evidence of Implementation: Standard Operating Procedure and Forecasting & Modelling Report Tracker included in AAA (Alert, Advise, Assure) report to Strategy, Planning & Performance Directorate Business Leadership Team meeting; formal review of IMTP from a forecasting and modelling perspective to go to Integrated Technical Planning Group and noted in AAA reporting up to Strategic Transformation Board.
		Medium Priority	Officer: Assistant Director Commissioning & Performance Date: 31 March 2026
Theme: Information, Data Quality & Data Accuracy		Control Design	

Key Findings	Risk & Impact	Agreed Management Action
2 Documented Procedures There is a small team responsible for carrying out forecasting and modelling activity within the Trust, consisting of a Senior Commissioning & Performance Analyst (within the Strategy, Planning & Performance Directorate) who is principally involved in modelling processes; and a Principal Analyst (Operations Directorate) who carries out forecasting work. However, there are no documented procedures to provide clarity and ensure consistency of approach. An initial version of a Standard Operating Procedure (SOP) has been developed to outline the Trust's structures and processes for the management of Omda Optima Predict (an externally provided software designed for testing hypotheses and scenarios). However, there is no documented guidance or templates to clearly detail roles and responsibilities (both internal and external) and clarifies the process for strategic, operational and tactical forecasting and modelling. Although forecasting processes are predominantly automated, not all the key staff that carry out forecasting and modelling activity have the same level of access to data, e.g. to a 'warehouse' to source key data independently. Capacity also needs to be considered for the management of the process including carrying out quality assurance checks and the development of supporting procedures. While we were advised that the Digital Service Directorate and external consultants could provide forecasting and modelling resource in the absence of key staff, business continuity arrangements would benefit from a review to ensure the processes in place are robust to enhance resilience.	Inconsistent processes leading to a lack of accountability and oversight.	Agreed Action: Complete the draft Standard Operating Procedure for Forecasting & Modelling. This would include approvals, version control, access to data and evaluations. The Executive Director of Strategy, Planning & Performance and Assistant Director Commissioning & Performance are currently reviewing the capacity of the Commissioning & Performance Team, of which forecasting and modelling is a part. As part of this review, we will consider business continuity for forecasting and modelling in the Trust.
	Medium Priority	Expected Evidence of Implementation: Standard Operating Procedure shown in AAA report to Strategy, Planning & Performance Directorate Business Leadership Team meeting; review of Commissioning & Performance Team's capacity/structure confirmed via Director.
Theme: Policies & Procedures	Control Design	Officer: Assistant Director Commissioning & Performance Date: 1 November 2025

Key Findings		Risk & Impact	Agreed Management Action
3	Terms of Reference The latest version of the Forecasting and Modelling Group's terms of reference (ToR) was provided, but the following weaknesses were identified: - Frequency of review: The ToR was approved by the Executive Director of Strategy, Planning & Performance in April 2024, but the document does not record how frequently it should be reviewed noting that good practice is that such documents should undergo a review at least annually. - Responsibilities: The content of the ToR needs to be updated to reflect the current position as it details that one of the Group's responsibilities is to develop and maintain the Trust's Forecasting and Modelling Framework. This has been de-prioritised due to limited staff capacity and other priorities. - Membership: Similarly, we were advised that the current membership of the Group is not reflective of that detailed in the ToR. - Escalation arrangements: The ToR does not detail escalation arrangements. Reporting arrangements are noted as the Group will report to the Executive Director of Strategy, Planning & Performance, who is the Executive Sponsor and that she will attend the Group once a year. Due to other priorities, she has been unable to attend as required.	Unclear roles and responsibilities leading to a lack of accountability and failure to deliver key priorities.	Agreed Action: Undertake annual review of terms of reference.
			Expected Evidence of Implementation: Updated ToR, approved in Strategy, Planning & Performance Directorate Business Leadership Team meeting.
	Theme: Governance	Medium Priority Control Design	Officer: Executive Director (Strategy, Planning & Performance Directorate) & Assistant Director Commissioning & Performance Date: 30 September 2025

As per *objective 1*, since 2020, the Trust has been employing forecasting and modelling techniques to enhance winter resilience planning. This was initially in response to the challenges posed by the Covid-19 pandemic, and has since been included in the annual winter plan submissions to Welsh Government. There are considerable pressures during the winter period, many of which are outside of the Trust's control such as prolonged hospital handover delays. During December 2024, the Trust declared a critical incident escalating the REAP to its highest level (Level 4) signifying the state of extreme pressure on services.

Historically, the Trust has procured modelling activities from external consultants, Omda, but the last exercise (2024/25) was carried out in-house with access to Omda's methodology and software; and support from a consultant where required. As per **Key Finding 2**, roles and responsibilities are not documented and templates are not utilised; but the methodology and data sources for the winter planning modelling exercise are well defined. We note that two scenarios are created for each of the four winter periods (1 October - 30 November; 1 December - 4 January; 5 January - 28 February; and 1 March - 31 March): MLS (Most Likely Scenario) and RWC (Reasonable Worst-Case Scenario).

Five predictor variables are used to forecast performance using the Omda Optima Predict software based on demand; time at scene; time at hospital; unit hour profile (UHP) (ratio of actual hours to planned hours of Emergency Ambulance (EA), Advanced Paramedic Practitioner (APP), Cymru High Acuity Response Unit (CHARU), and Urgent Care Service (UCS) vehicles); and implemented operational change (the changes to the Trust's operation that are expected to be implemented by the time of the corresponding winter periods).

The outcomes of the latest winter modelling exercise are clearly detailed (see **page 3**) noting that the '% Red <8 minutes' performance target has not been met in scenario planning (which was the same position as the previous winter). Data limitations are recorded in the wider winter modelling report, but the content needs to be more explicit on data assumptions used (see **Key Finding 4**).

We were advised that the Omda consultant reviewed the outputs as this was the first time the Trust had undertaken the winter modelling exercise in-house, but this cannot be evidenced (see **Key Finding 1**). Furthermore, there is no documentation confirming the discussion and approval of the report presented to the Forecasting and Modelling Group (26 September 2024) (see **Key Findings 1** and **5**). Noting the Trust's intention to continue this work in-house, it would be beneficial to incorporate Welsh Government's winter modelling scenario planning in future exercises and to validate how the model outputs align with actual performance (see **Key Finding 4**).

The winter plan, which is linked to the Trust's IMTP priorities, was discussed at the Operations Directorate Senior Leadership Team's meeting (26 November 2024) where some minor amendments were incorporated, but there is no record of its approval (see **Key Finding 1**). The document details an action plan for each of its key objectives, including ensuring "*capacity planning is connected to forecasting and modelling for winter is undertaken*". Currently, there is one action for this objective that has not been recorded as completed (forecast and model 111 performance through the winter period). The Assistant Director (Commissioning and Performance) confirmed that this task had been undertaken, but there was a recognised need for further improvement to enhance the accuracy of predicted performance for the next winter period. Forecasting on 111's capacity is in place, and it is anticipated that the external review of 111 rosters will include predictions of performance.

For the 2023/24 winter planning exercise, there was reporting to both the Finance and Performance Committee and the Trust Board on forecasting and modelling activities, but there was no similar reporting for the 2024/25 period (see **Key Finding 6**). While the planning process is considered as 'business as usual', there needs to be an appropriate balance to ensure there is sufficient oversight and scrutiny of current arrangements. Similarly, while there have been reflections of risks and lessons learnt from the last winter planning exercise, e.g. to Welsh Government, there is not a robust mechanism for recording and sharing organisational learning (see **Key Finding 7**).

Key Findings		Risk & Impact	Agreed Management Action
4	Winter Resilience Planning The following weaknesses were identified in the winter planning process: - While the Winter Modelling (2024/25) provides a comprehensive overview of data limitations, the data assumptions are not recorded, e.g. average time in hospital. - Consideration was not given to the Welsh Government's (WG) 2024/25 Winter Modelling scenario planning (September 2024) when developing the Trust's exercise. The WG's report provides retrospective analysis, comparing actual performance against the winter modelling scenarios for 2023/24. The Trust has not got a robust tool to undertake similar analysis (assessing actual outputs to those forecasted and modelled) to identify good practice and determine whether any enhancements are necessary for future modelling and forecasting.	Winter resilience forecasting and modelling is ineffective with a failure to mitigate demand and capacity changes potentially impacting patient safety and staff wellbeing.	Agreed Action: As part of the Forecasting & Modelling SOP, confirm the template(s) to be used for in-house reports. Build WG winter modelling scenario work into the SOP.
			Expected Evidence of Implementation: Forecasting & Modelling SOP approved in SP&P BLT meeting. Forecasting and modelling reports incorporating WG analysis and data assumptions
	Theme: Information, Data Quality & Data Accuracy	Medium Priority Control Design	Officer: Assistant Director Commissioning & Performance Date: 1 November 2025

The dedicated Forecasting and Modelling Group convenes informally on a weekly basis while also holding more formal monthly meetings that adhere to a set agenda and an action log. However, the absence of dedicated administrative support has resulted in a lack of documented evidence regarding the quoracy and key outcomes of these meetings. Consequently, updates are primarily communicated verbally, rather than through written reports. Although a work plan has been established, it has not been consistently maintained due to limitations in staff capacity (see **Key Finding 5**).

Recognising the need for enhanced governance arrangements within the Trust, particularly with operational governance, an integrated governance map has been developed. This map outlines principles designed to ensure effective oversight and accountability across its meetings; provide clarity over roles and responsibilities; and improve the administration of meetings. The Forecasting and Modelling Group is included under the Strategy, Planning & Performance Directorate within this governance framework, but the extent of oversight regarding forecasting and modelling activity within the Trust could not be easily demonstrated despite some recent reports encompassing this content (see **Key Finding 6**).

The Trust has yet to establish a systematic approach to reflect on the successes or lessons learned from forecasting and modelling activities (see **Key Finding 7**). While individual instances exist, such as with the 111 service Christmas forecasting, there is currently no routine mechanism in place to capture and analyse them and record the action taken for any improvement identified.

Key Findings	Risk & Impact	Agreed Management Action
5 Forecasting and Modelling Group Meeting Administration The existence of a multi-disciplinary Forecasting and Modelling Group is a positive step in collaborative working, but it was difficult to evidence the level of discussion and scrutiny of modelling and forecasting activity as key decisions are not recorded, e.g. within a decision log. Predominantly, verbal updates were provided due to staff pressures. We were advised that written reports are provided where there is a particular forecasting or modelling output to be discussed, e.g. Omda report, but that some of the written reports may have gone to the informal weekly meetings rather than the monthly meetings that have a structured agenda. Similarly, while the Group's terms of reference detail the quorum arrangements, e.g. Chair or Vice Chair to be present along with a JCC representative, nothing is recorded to confirm the meeting attendance (also refer to Key Finding 3). A workplan and project tracker has been recently implemented however, its effectiveness is currently limited by staffing constraints, noting a lack of dedicated administrative support	Meetings may not be effective if they are not planned appropriately, and there may be a lack of accountability of issues escalated.	Agreed Action: Introduce a AAA report for the Forecasting & Modelling Group and confirm governance route. Continue to strengthen focus on work plan through the F&M Group, as it was only recently introduced before the audit. Expected Evidence of Implementation: AAA reports (taken to SP&P BLT meeting).

Key Findings		Risk & Impact	Agreed Management Action
	within the team. The workplan has nine actions recorded, but four do not record a timescale. Similarly, the project tracker has 16 actions, but timescales were unclear for seven actions and nine actions were overdue.		Use an up to date work plan – articulated through the AAA.
	Theme: Governance	Medium Priority	Officer: Executive Director (Strategy, Planning & Performance Directorate) & Assistant Director Commissioning & Performance Date: 1 November 2025
6	Oversight of Forecasting and Modelling activity The Forecasting and Modelling Group's (FMG) terms of reference note that the "<i>Group will report to the Executive Director of Strategy, Planning & Performance who will determine the subsequent flow of information into the relevant setting.</i>" While verbal updates are provided to the Executive Director, who serves as the Executive Sponsor for the Group, there is a lack of clear onward reporting from the Group and the extent of oversight within the broader Trust governance framework could not be easily demonstrated. There was evidence of recent engagement that incorporates reporting of forecasting and modelling activity. For example, reporting to the Operations Directorate's weekly performance review meeting and Senior Leadership Team (SLT) meetings. However, wider reporting to Trust Board and its committees has been restricted to a closed session of Finance and Performance Committee (FPC) (16 July 2024) on the outcomes of the Emergency Medical Services (EMS) Demand and Capacity Review; and to both the FPC (17 September 2024) and the Trust Board (26 September 2024) concerning the closure of the EMS Operational Transformation Programme Board. As highlighted in <i>objective 2</i>, there was no reporting to the Trust Board or its committees on the recent winter planning exercise.	Ineffective reporting could result in poor decision making and a lack of accountability and oversight.	Agreed Action: Introduce AAA reports at FMG and SP&P BLT. Winter modelling to be reported formally into Operations SLT.
			Expected Evidence of Implementation: AAA reports (FMG and SP&P BLT), Operations SLT AAA report into ELT to show evidence of the winter modelling discussion.
	Theme: Governance	Medium Priority	Officer: Assistant Director Commissioning & Performance Date: 31 October 2025
		Control Operation	

Key Findings		Risk & Impact	Agreed Management Action
7	Organisational Learning There is no formal mechanism in place to capture good practice and lessons learnt arising from modelling and forecasting activity. As noted in <i>objective 2</i>, there have been no reflections from the 2024/25 winter planning exercise, but wider consideration is required to prompt if elements of the forecasting and modelling process needs to be corrected for future planning. We noted evidence of continuous improvement within Trust Board reporting (March 2025 - Actions to mitigate avoidable patient harm in the context of extreme and sustained pressure across urgent and emergency care); operational performance meetings in relation to the 111 Christmas forecasting (as noted in <i>objective 2</i>); and the EMS Operational Transformation Board Closure Report incorporated some lessons learnt in relation to the forecasting and modelling for the roster review. However, there is no structured process to prompt for these to be shared and to ensure that delivery of any actions arising from lessons learnt are effectively monitored.	Ineffective organisational learning could lead to missed opportunities for improvements and poor decision making.	Agreed Action: The Forecasting & Modelling Report Tracker will record lessons learnt.
			Expected Evidence of Implementation: Forecasting & Modelling Report tracker; and identified as part of the AAA reporting up to SP&P BLT.
	Theme: Lessons Learnt	Medium Priority Control Design	Officer: Assistant Director Commissioning & Performance Date: 1 November 2025

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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 management of the Welsh Ambulance Services University 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.

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Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated 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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Start of Shift Procedure

Final Internal Audit Report

2024/25

Welsh Ambulance Services University NHS Trust



Limited Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	3
Appendix A: Assurance Opinion & Prioritisation of Findings.....	12

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

WAS-2425-11

April – May 2025

12 June 2025

24 June 2025

Lee Brooks, Executive Director of Operations

Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit



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Executive Summary

Purpose

To assess compliance with the Start of Shift procedure, including the preparation of vehicles and to ensure that key equipment and medicines are available.

Overview

The Trust’s ‘Shift Start and Finish’ Standard Operating Procedure (SOP), which was last reviewed in March 2024, sets out an agreed process for staff during the commencement and completion of operational shifts, which includes coverage to comply with the requirements of the Road Traffic Act 1998. These arrangements apply to all operational staff within Emergency Medical Services (EMS) and Ambulance Care, and exist to ensure increased efficiencies at the commencement of each shift.

Section 5 of the document clearly sets out the requirements that should be followed by staff when they start their shift, and such has formed the basis of the individual objectives at this review.

Whilst we recognise, anecdotally, that such checks are completed by staff, there is limited evidence available to support and minimal reporting to confirm overall compliance with expectation. Accordingly, we have concluded **limited assurance** on this area. The matters requiring management attention include:

- Review the content of the SOP to align with current practices, including the distinction between expectations for Ambulance Care and EMS as well as training to be undertaken to increase the awareness of the document and the expectations within;
- To address non-compliance with the SOP, consideration of an electronic solution to record, and approve, the completion of the checks required before the start of a shift; the output of which will be saved in a central repository;
- Scheduled reviews of consumables held on the Trust vehicles to rationalise and therefore prevent wastage and excessive ordering; and
- Routine reporting to be undertaken in relation to the compliance with the SOP, which the data collated from an electronic solution could support.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	The ‘Shift Start and Finish’ SOP clearly sets out the requirements to be followed and is communicated and made available to all staff.		1, 2	Reasonable
2	Staff book onto the MDT immediately at the commencement of shift which aligns with their working pattern.		-	Substantial
3	The checks required before mobilising to any call, as defined with the SOP, are completed and evidenced appropriately.		2, 3	Limited
4	For instances where mobilisation checks are not possible (i.e. red incident allocation) this is effectively communicated as per the SOP and evidenced as complete at the earliest opportunity.		3, 5	Limited
5	Clinical and equipment checks including morphine are completed at the first available opportunity within the shift, with escalation of any missing or deficient equipment or medication.		4	Reasonable
6	Periodic reports on the compliance with SOP are produced and submitted to appropriate management and Trust committees for oversight and escalation.		1, 3, 5	Limited

Management Actions

2

High Priority

3

Medium Priority

Themes



- Policies & Procedures
- Governance
- Reporting
- Information, Data Quality & Data Accuracy
- Quality, Safety & Patient Experience

Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Procedures

Reasonable

The 'Shift Start and Finish Standing Operating Procedure' (the SOP) is clear and concise in terms of setting out the requirements of staff for both the start and finish of a shift, with Section 5.1 specifically focused on the start of shift arrangements. The SOP is saved on the Trust's Siren page and therefore accessible to all, however, the outcome of an Ambulance Care Quality & Support Day (February 2025) noted that approximately 25% of staff were not aware of the SOP (see **Key Finding 1**).

Coverage of the SOP includes completion of the legal Vehicle Daily Inspection (VDI) checks to comply with the Road Traffic Act, Personal Protective Equipment (PPE) checks; and clinical and equipment checks (see *objective 5*). Detail is also provided in respect of expected time completion of the checks, with 15 minutes determined for a 'cold vehicle' (as per the SOP: *where the vehicle has not been taken over from another crew*); and 10 minutes for others. Appendix 1 to the SOP provides the checklist to be completed by staff as part of these arrangements. Discussions held with staff noted that it is not deemed achievable to undertake all the required checks within the time dedicated - regardless of whether they are allocated to a call at the start of a shift. We also acknowledge that for those stationed at a Make Ready Depot (MRD), there is an assumption such would permit more 'ready' vehicles available; however, noting the current system pressures with handover delays this is not always achievable.

As per the VDI form, there are 26 checks expected to be completed (14 of which have been highlighted as high importance). We also note that on each vehicle is the MDVS (Mobile Data Vehicle System) which includes checks to replicate those included in the VDI - to be signed off as pass/fail. There are a total of 11 checks included on the MDVS. Review of the detail across both has determined that the MDVS covers the same checks listed, however, the VDI is more specific in the expected coverage. For example:

Action as per VDI form	Action as per MDVS
Carry out a general bodywork check looking for damage or anything that could cause a hazard, report any new damage in the defect book.	Body work and number plates
Walk round all automatic emergency lighting check.	All lights, reflectors and indicators.
Check all light, reflectors, side, head rear, stop and indicators, fog and hazard warning lights are working correctly	

There is no reference within the SOP as to the expectation for the pass/fail acceptance of the MDVS, and the timeframe within which such should be completed following commencement of the shift; and whether such is a supplement or replacement to the VDI checks as currently referenced (see **Key Finding 2** and *objective 3* for further details in relation to completion of the checks).

Key Findings		Risk & Impact	Agreed Management Action
1	Awareness of the SOP In February 2025, as part of the Quality & Support days, Ambulance Care focused on enhancing the operational efficiency and safety of ambulance services, particularly through the lens of Shift Start and Vehicle Security during shifts. Weaknesses were noted in relation to awareness of the SOP; as well as completion of expected forms (see Key Finding 3) and the time taken to be taken to complete the checks. As has been reported within the Operations Quarterly Sub-Report (Q4) such has highlighted a training need. Whilst it is appreciated these results are specific to Ambulance Care, consideration should also be given to understanding the current practices applied within EMS to confirm awareness of the SOP.	Non-compliance with legal requirement for vehicle checks.	Agreed Action: Communications will be circulated to reinforce the SOP and its contents. The timing of this will coincide with the release of an updated SOP (as reflected in Key Finding 2).
			Expected Evidence of Implementation: Copy of the communications.
		Medium Priority	Officer: Sonia Thompson (Assistant Director of Operations, EMS) and Mark Harris (Assistant Director of Operations, Ambulance Care)
	Theme: Policies & Procedures	Control Design	Target Implementation Date: October 2025
2	Update to SOP to reflect current practices As detailed within the SOP for Start of Shift arrangements: <i>'staff must complete their legal VDI checks (Appendix 1) to comply with the Road Traffic Act, prior to mobilising any call.'</i> As reported from a recent Quality & Support day, only 50% of those in Ambulance Care are completing the forms alongside the acknowledgments included in the MDVS; with the rest only using the MDVS. However, there is no reference to MDVS within the SOP which could raise confusion as to whether such is a supplement to, or replacement for, the VDI checks. Further, whilst the headings as per the MDVS correlate with the primary checks as included in the VDI form, the latter provides more detail/guidance for the driver completing. It is also noted that, as a result of the recent Quality & Support Day, (see objective 5) there is a need to update the SOP to align with the needs of the NEPTS/Ambulance Care teams to <i>'ensure that all staff regardless of their specific roles are on the same page regarding shift commencement procedures.'</i>	The legal requirements for vehicle checks are not completed appropriately.	Agreed Action: The Vehicle Accident Management Task & Finish Group are currently reviewing VDI processes within the Trust in line with the Vehicle Accident Management Internal Audit actions. Given the correlation with this audit, the scope of this group will be expanded to include Start of Shift SOP arrangements. On agreement of the new process from the Task & Finish Group, the SOP will be updated to reflect current practice. Senior Operations Team (SOT) will maintain oversight and responsibility of this audit action.
			Expected Evidence of Implementation: Triple As from the Task & Finish Group to confirm agree process; copy of updated SOP to reflect practice and copy of SOT Triple A to approve amended SOP.
		Medium Priority	Officer: Ben Collins (Head of Service, EMS South Central)
	Theme: Governance	Control Design	Target Implementation Date: October 2025

Objective 2: Booking onto system at commencement of shift

Substantial

The SOP states that: *'staff must book onto the MDT immediately at the start of shift.'*

There is no monitoring of the time staff book onto the system versus the time their shift commences. However, the mapping of shift patterns for the day is known by the Resource Coordinators at EMSC (Emergency Medical Services Coordination). Should there be no activation /availability of the expected crew members then contact will be made with the assigned Locality Manager / Duty Officer Manager to rectify the situation. Sample testing was unable to be undertaken in this area as there is no formal expectation of reporting between the two systems; issues regarding attendance will be picked up separately through observation and/or concerns logged by fellow members of staff.

During the course of audit fieldwork, a site visit was undertaken at the Cardiff MRD. During the time on site, there were three shift allocations – 06:30hrs, 06:45hrs and 07:00hrs. From observation, it was clear that the staff were logged on and available at the earliest opportunity post arrival; noting that all crews had been dispatched to calls by 07:15hrs.

The same was applicable during the site visit undertaken at the Cardiff East Ambulance Station. Again, through observation and discussion, noting the planned nature of the work undertaken by the Ambulance Care staff at this site, the shifts are timed accordingly to allow the vehicle checks to be completed prior to departure for the allocated journeys of the day.

Objective 3: Completion of checks prior to mobilising to a call

Limited

The SOP states that: *'while undertaking these daily checks you may be auto-allocated to a Red incident. If you have not completed the required vehicle or PPE checks and a call is allocated, then inform EMSC. You will be expected to mobilise at the earliest opportunity and back up can be requested if required.'*

Recognising the service pressures at this present time, it has become the norm to expect to be allocated a red / amber call soon after commencement of a shift. This doesn't permit sufficient time to complete all of the checks as detailed on the VDI form and within the content of the SOP. We were advised that anecdotally, experience has led to reflect on what are the 'core' checks to complete at the start of the shift to allow the vehicle to enter the road safely and respond to a call. Such has been identified as tyre checks, lights, Ad-Blue levels, sufficiency of drugs, and equipment. The site visit to Cardiff MRD witnessed these checks being completed as a minimum before being dispatched to a call (noting all crews on shift during the visit had been dispatched within 10-15 minutes of their start time). It was confirmed that the rest of the checks required would be done at the earliest opportunity, some of which could be whilst waiting to handover a patient at the hospital. There was, however, no reference to reporting back to EMSC that not all checks as per the SOP had been completed prior to dispatch.

With regard to the checks completed by Ambulance Care, noting the planned nature of the work, there should be no issue with the completion of the required checks prior to commencing the journeys allocated. The requirements of the VDI form are the same across services; but there will be differences in terms of clinical and equipment checks due to the nature of provision. However, as per **Key Finding 2**, such is not defined within the SOP.

There was no evidence of a central repository for completed forms; although this is not to say that such are being completed and retained at individual stations. However, at the two site visits undertaken, there was no evidence of documentation retained to support the completion of the checks nor physical sight of forms being used as the checks were being undertaken. As per the site visits, the completion of the screen on the MDVS is deemed the completion of the checks (although it is noted that 'pass' can be selected to be able to log off at the end of the shift without actually having completed the relevant checks).

As noted at the Quality & Support days, there is some confusion as to whether the MDVS is a replacement or supplement to the VDI form (see **Key Finding 2** and *objective 6*).

Without the evidence of the completed and signed checks (as the VDI form suggests), there is the risk of non-compliance with the Road Traffic Act should an incident arise whilst attending a call. A similar issue regarding form completion was raised at our recent Vehicle Accident Management review (issued February 2025: Limited Assurance). Noting that completion of a paper form could be deemed cumbersome, within the time period permitted at the commencement of a shift, consideration should be given to developing an electronic form, via the iPads used by crew members, to be submitted to a central repository (see **Key Finding 3**).

Key Findings		Risk & Impact	Agreed Management Action
3	Lack of evidence to demonstrate compliance of checks As has been identified through the recent Ambulance Care Quality & Support day, 50% of the staff involved (circa 162) completed the paper-based forms as per the SOP. It is not clear as to the completion rate for EMS as such was not the focus for their Quality & Support day; however, the site visits undertaken during the course of audit fieldwork noted that no forms were completed and retained post completion of the checks. Recognising the legal requirement for the completion of these checks, and wider compliance with the SOP, consideration should be given to the development of an electronic version of	Non-compliance with legal requirements.	Agreed Action: The Vehicle Accident Management T&F Group are currently reviewing VDI processes within the Trust in line with the Vehicle Accident Management Internal Audit actions, this includes the process to demonstrate compliance and reporting of checks. Given the correlation with this audit, the scope of this group will be expanded to include Start of Shift SOP arrangements. SOT will maintain oversight and responsibility of this audit action.

Key Findings	Risk & Impact	Agreed Management Action
the VDI form, to be made available via the iPads. The receipt into a central mailbox / repository would allow for a date/time stamp to be actioned therefore providing an opportunity to understand the timeframe for completion amongst crews – the output of which can be reported and escalated as appropriate. Consideration could also be given to the inclusion of sign off for clinical and equipment checks noting there is no specified requirement, as per the SOP, for such to be documented (see <i>objective 5</i>).	High Priority	Expected Evidence of Implementation: Triple A repots from the Task & Finish Group to confirm discussions on the VDI process and reporting mechanisms; and an updated version of the SOP.
Theme: Information, Data Quality & Data Accuracy	Control Operation	Officer: Ben Collins (Head of Service, EMS South Central) Target Implementation Date: October 2025

Objective 4: Communication of mobilisation checks

Limited

The SOP states that: *'it is expected that crews will be able to respond to all incidents at the conclusion of these roadworthy vehicle and PPE checks, and all other checks will be completed during the shift, or as soon as possible. Any instance where this is not possible must be discussed with EMS-C at the earliest opportunity and logged accurately.'*

As a consequence of the lack of evidence to demonstrate that checks are being undertaken, and noting we have been informed that they are not all undertaken in the majority of cases before the crew is despatched (see *objective 3*), it limits the ability to provide assurance in respect of this objective.

Discussions were held with an EMS-C administrator, and an Operational Team Leader for Ambulance Care, to confirm the process for the communication of mobilisation checks. Should issues be identified they will be logged with the Resource Coordinator so that adjustments can be made to the shift allocations accordingly. In terms of reporting, there is functionality with the C-3 booking system (EMS) but such has not been requested (in terms of the time that the update is provided versus the start time of the shift). This correlates with the wider point regarding lack of reporting for compliance with the SOP (see **Key Findings 3 and 5**).

Overview / Summary of Observations

The SOP states that: '*clinical and equipment checks including morphine should be completed at the first available opportunity within the shift but not necessarily prior to the mobilisation to a call and any missing or deficient equipment or medication should be appropriately escalated via the EMS-C to rectify as soon as is practicable.*'

With regards equipment and consumables, there is a standard list for inclusion, as a minimum, on an EMS vehicle. However, there isn't sufficient time at the commencement of the shift to work to tick off each of the items. During the course of the site visit to Cardiff MRD, a walkthrough of the consumables held within a vehicle saloon was completed. It was clear that there was a multitude of items which could have been condensed to match the listing, recognising that expiration dates apply (see **Key Finding 4**). It is recognised that this is a wastage issue rather than a patient safety issue.

Where items of equipment are missing or deficient, initial consideration will be given to other vehicles that are at the respective station. Some may be awaiting collection from fleet and therefore, subject to whether there is an issue with the equipment on board, such can be obtained for fulfil the requirements. Any changes will be communicated to the Locality Manager / DOM with details recorded on the white boards that are maintained at the stations for the allocated vehicles. Where located at a MRD, as was observed with the site visit to Cardiff MRD, enquiries will be made of the stock maintained to address any missing and deficient instances.

In terms of the clinical requirements, there are core items that will be reviewed, including the oxygen tanks, the 'grab bag', saline, and core drugs. It is noted that not all drugs will be held at the relevant stations, although where an Omincell cabinet is located this will be accessed to replenish what is required. Discussions held with a Senior Paramedic during the site visit confirmed that previous crews will replenish what has been used during the response, to the minimum level, as access can be made of the Omincell cabinets at the hospital sites.

Key Findings	Risk & Impact	Agreed Management Action
4 Review of Consumables There is a minimum list of expected consumables and equipment to be retained on EMS and Ambulance Care vehicles. Noting the lesser amount on the latter it is easier to maintain a regular stock check of the items. However, with EMS, there is the risk that crew members will pick up what they think is needed within the time period available to complete the check rather than there being a routine stock count completed, which will also pick up expiry dates for items. We appreciate that consumables review will be undertaken on behalf of the paramedics at MRDs; however consideration should be given to a regular scheduled review of consumables at the stations or through the MRD as part of the wider cleaning schedule to rationalise the consumables held and prevent wastage / excessive ordering.	Overstocking of consumables on vehicles can lead to increased wastage costs for the Trust.	Agreed Action: The Trust accepts this finding and recognises that whilst there is a list of minimal consumables in MRD this currently is not applied at ambulance stations. The Operations Directorate will share comms to staff on the minimal list of consumables required for Vehicles to reinforce the amount that needs to be held. The list will also be placed on all relevant vehicles. Consideration will also be given to incorporate a regular scheduled review of consumables. Expected Evidence of Implementation: A copy of list of consumables that will be added to vehicles, a copy of the comms to reinforce the consumable amounts and Triple A from EMG (EMS Management Group) and Ambulance Care Service Management Meeting to confirm discussions on scheduled review consideration.
	Medium Priority	Officer: Sonia Thompson (Assistant Director of Operations, EMS) and Mark Harris (Assistant Director of Operations, Ambulance Care)

	Theme: Quality, Safety & Patient Experience	Control Operation	Target Implementation Date: October 2025

Objective 6: Reporting

Limited

During the course of audit fieldwork, a number of discussions have been held with officers (Locality Manager and Duty Operations Manager for EMS; and Service Manager and Operational Team Leader for Ambulance Care) to understand the reporting that can be extracted from systems to determine staff compliance with the SOP.

In all instances, there was no awareness of regular analysis or reporting being completed which could be used as a performance tool to confirm compliance (see **Key Finding 5**). Noting that the vehicles are out on the road and available for response / patient journeys, there is the assumed understanding that the requirements of the SOP have been addressed as those not deemed fit for purpose will be reported through the EMS-C (see *objective 4*) and alternative vehicles, if available, will be allocated for the relevant crews.

As noted in objective 1, the Quality & Support Day undertaken in February 2025 had a specific focus on Start of Shift arrangements for those in Ambulance Care. The outcome of this day has been included in the Operations Quarterly Sub-Report (Q4) which was recently presented to the Quality, Patient Experience and Safety (QuEST), People & Culture and Finance & Performance Committees at their respective May 2025 meetings. There is no evidence of such having been assessed for those within EMS and reported accordingly (see **Key Finding 1**).

The 3 main areas included within the sub-report are detailed as follows, the actions from which correlate with the findings included at this report:

- Approximately 25% of staff were not aware of the Start of Shift Standing Operating Procedure – this highlights a significant gap in communication and training, suggesting that more efforts are need to ensure all staff are familiar with these crucial guidelines;*
- Vehicle Daily Inspection processes showed variability with 50% of staff completing paper-based forms alongside MDVS acknowledgement while the other 50% relied solely on MDVS acknowledgements – this inconsistency points to the need for a standardised approach to VDI completion to ensure thorough and uniform checks (see **Key Finding 3**)*
- There was confusion among staff regarding the correct procedure for completing a VDI for a cold vehicle – responses varied from 5 to 30 minutes whereas the correct procedure stipulates 15 minutes – this indicates a need for clearer instructions and training to ensure staff are aware of the proper protocols.*

Key Findings	Risk & Impact	Agreed Management Action
5 Reporting There is no evidence of routine reporting being undertaken to measure compliance with the SOP, timeliness and accuracy of completion to permit escalation of concerns, should they be identified. Whilst the output of the Quality & Support day has been reported at Committee level, this related to an exercise completed in quarter 4 and was only in relation to Ambulance Care. The use of a central repository for completed forms (see Key Finding 3) would help facilitate reporting. Theme: Reporting	Management are not aware of any issues associated with the completion of start of shift arrangements. High Priority Control Operation	Agreed Action: EMG (EMS Management Group) will review the main key points of the SOP and potential compliance measurements and will complete a dip sample exercise based on the key components to review compliance and discuss next steps to include regular routine reporting. SOT will maintain oversight and responsibility of this audit action. Expected Evidence of Implementation: Triple A from EMG into SOT to determine the discussions on the SOP and the results of the dip sample, next steps discussion. Officer: Ben Collins (Head of Service, EMS South Central) Target Implementation Date: December 2025

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated 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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Emergency Communication Nurse System Implementation Final Internal Audit Report 2024/25

Welsh Ambulance Service University NHS Trust



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	3
Appendix A Assurance Opinion & Prioritisation of Findings	15

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

WAST-2425-12

February - April 2025

29th May 2025

June 2025

Lee Brooks, Executive Director of Operations

Osian Lloyd, Head of Internal Audit; Felicity
Quance, Deputy Head of Internal Audit

Executive Summary

Purpose

To provide assurance that benefits realised reflect those identified at the outset of the Emergency Communication Nurse System (ECNS) implementation.

Overview

The implementation of the ECNS system within the Trust's Clinical Support Desk (CSD) provided a key tool to support secondary triage of patients calling 999, aligning with the strategic ambition to enhance its remote clinical care provision. The adoption of ECNS built upon the lessons learnt from prior Clinical Contact Centre reviews and reflection from the operational response to the Covid-19 pandemic. It provides a more robust, evidence-based, digitally integrated system in comparison to the previous paper/pdf-based triage tool, offering consistency of questioning, advice and efficiencies of process through areas of automated functionality. The Trust has subsequently received accreditation as a Centre of Excellence in September 2023.

This review is not an assessment of the system implementation itself and is cognisant of the significant system challenges faced by the wider Urgent and Emergency Care system which would continue to impact the Trust and in turn the realisation of some related ECNS benefits. Further, this review did not include the recent integration of the ECNS within the wider 111 service; the safe and effective operation of 111 has been assessed within the 111 Digital Operations review (issued December 2024: substantial assurance).

We have concluded **reasonable** assurance on this area.

The matters requiring management attention include:

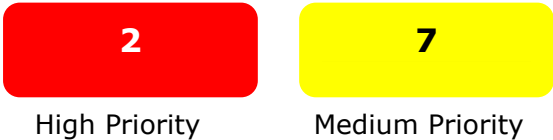
- The proposal for investment relating to ECNS included a high-level outline of benefits or outcomes related to system implementation, however this was not accompanied by further refinement of targets, criteria or timescales.
- No post implementation review has been undertaken, resulting in the absence of an evaluation of benefits realised, and identification of lessons learnt.
- Current audit arrangements vary in the degree of coverage resulting in 48% of clinicians not receiving a review in August 2024 and November 2024.
- Capacity issues have resulted in a three-month backlog of ECNS audits (quality assurance reviews of triage calls against the International Academies of Emergency Dispatch (IAED) performance standards), with corresponding effect on timeliness and impact of feedback. In November 2024 the Trust's non-compliance rate was 28%, against the IAED target of 7%.
- Performance Delivery Plans to address periods of underperformance, as outlined within the Quality Assurance Framework, are not in place. Existing gaps in audit coverage across CSD would also impact the ability to identify outliers and prompt plan usage.
- There could be greater standardisation of feedback format and terminology, to provide a clearer link to the ECNS Performance Standards and the categorisation of deviations identified.
- A business case for the transfer of the responsibility for undertaking ECNS audits has been developed, however timescales for completion of the move are yet to be confirmed.
- Reporting arrangements for ECNS have recently been refreshed and will require time to develop and mature. Reporting includes actions to address non-compliance, however these lack the formality of an action plan to monitor progress.
- There was no evidence of escalation of ECNS non-compliance, noting such may impact the Trust's accreditation as a Centre of Excellence, within wider Trust reporting or at committee level.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	Programme benefits were appropriately identified and clearly defined at the outset.	1	Reasonable
2	The achievement of benefits were monitored and reported regularly during the implementation period, and mechanisms to ensure the quality of service remain in place.	2, 3, 4, 5, 6	Limited
3	Benefits not realised at the close of the programme continue to be subsequently monitored to completion.	6	Limited
4	Lessons learnt have been identified from the programme, including feedback gained through patient and staff experience, to inform immediate and future service changes.	1, 6	Reasonable
5	Appropriate governance and reporting arrangements have been established post-implementation and operate as intended.	2, 7, 8, 9	Reasonable

Management Actions



Themes



Risk Types

- Public Perception & Reputational Risk
- Legal & Regulatory Non-Compliance
- Choose an item.
- Choose an item.

Findings & Agreed Action Plan

Objective 1: Programme benefits were appropriately identified and clearly defined at the outset.	Reasonable

The case for the adoption of ECNS, a clinical decision support software, was outlined in 2021 within the '999 Remote Clinical Triage Support systems, Quality and Safety. A Proposal for Investment' ('the investment case'). This referenced both the Trust's ambition to further develop its remote clinical triage capacity, to build upon a clinical review of Clinical Contact Centre ('the CCC clinical review') undertaken in 2019; and lessons learnt from operational changes made as part of the organisation's response to the Covid-19 pandemic.

The adoption of ECNS was to replace the Manchester Triage System (MTS); a set of 53 paper/pdf process flow charts primarily designed for face-to-face use. In comparison ECNS offers over 250 distinct algorithms: providing age and gender specific clinical triage protocols, with the ability - through assessment and critical thinking - to arrive at an appropriate recommended care outcome, alongside consistent self-care instructions.

The investment case also compared the limitations of MTS: noting a lack of integration with other Trust electronic systems resulting in limited opportunities to generate data for the quality assurance and quality improvement of calls, which ECNS functionality addressed. ECNS also included an integrated audit tool ('Ascent Quality Assurance' or 'AQUA') which, through its alignment to the International Academies of Emergency Dispatch (IAED) performance standards, would provide a system to ensure the consistency and quality of calls. This in turn would lead to both improved patient experience and outcomes. System implementation would include the establishment of a new Professional Practice Education (PPE) team to provide training, coaching and audit capacity, with the investment case specifying the need for an educator to clinician ratio of 1:10 (c.6WTE).

The investment case also noted that through the system's data capture and call structure, there would be opportunities to reduce the average call time from 19 minutes to between 11-15 minutes; with associated productivity and financial savings forecast. Opportunities to increase the 'hear and treat' (now known as 'consult and close') rates were also noted. The benefits which could be seen within the wider health system were also referenced, which included increased numbers of patients triaged, reduced number of ambulance conveyances, reduced number of patients attending Emergency Departments, and associated impact on handover delays.

Whilst the investment case contained the identification and description of benefits and outcomes; targets, criteria or timescales to achieve these were not set out (**See Key Finding 1**).

The implementation period coincided with a number of other service changes, notably the expansion of the Clinical Support Desk (CSD) through the integration of an additional 36 paramedics, and establishment of a dedicated Mental Health clinician team. The Senior Responsible Owner and project manager have both since left the organisation, but other key contacts noted the pace and impact of these changes as contributing factors to the lack of supporting documentation.

In 2024, the Trust introduced a formal Project Plan Pathway toolkit which provides guidance, templates and defines roles and responsibilities between senior responsible owners, change managers, and project support; and the implementation of this should help address the issues above within future projects.

Key Findings		Risk & Impact	Agreed Management Action
1	Benefit realisation gap analysis While the investment case outlines high-level benefits or outcomes, noting some would be immediately evident in comparison to the previous triage system, these were not accompanied by definitions of baseline measures, target criteria, or timescales and leads. The mapping of the above would have allowed assessment and measurement of the extent to which the benefits have been realised.	Gaps within the approach to the identification and definition, to the failure to realise benefits.	Agreed Action: The Trust accepts this finding and agrees with the need for broader learning and clarity at the outset of developments such as this. As set out, the publication of the Project Plan Pathway published in 2024 is anticipated to address this finding going forward and therefore the Trust is satisfied that this action is addressed.
			Expected Evidence of Implementation: Closed
	Theme: Planning, Delivery & Deadline Management	Medium Priority Control Design	Officer: N/a Target Implementation Date: N/a

Objective 2: The achievement of benefits were monitored and reported regularly during the implementation period, and mechanisms to ensure the quality of service remain in place.

Limited

Benefit achievement: An ECNS Project Plan was developed to direct implementation commencing in November 2021 and system launch on 17 May 2022. This contained key actions and timescales for the rollout of underlying infrastructure, user acceptance training, and deadlines for the submission of evidence to support accreditation as a centre of excellence (ACE). As per *objective one*, ECNS implementation was initially a deliverable within the CCC Clinical Review project, and in December 2022 ECNS was included within the transfer of the remaining CCC project actions to the Trust's Gateway to Care (G2C) Programme. Review of programme highlight reports provided RAG rated updates in progressing these structural and workforce changes. We note this did not include specific review of ECNS benefits, and no post implementation report could be provided to demonstrate any detailed assessment of these. (See **Key Finding 6**).

CSD performance dashboards capture ECNS related indicators, which include call times, protocol use, outcomes, and call conversion to consult and close on both a CSD service wide and individual clinician basis. Review of the reports indicate reductions in call times have not materialised in line with the expectation of the investment case, remaining consistent with pre implementation averages; but consult and close levels have seen an increase (March 2021 – 6%, September 2024 – 9.6% - *Trust Monthly Integrated Quality & Performance Report*).

The Trust has been successful in gaining ACE for its use of ECNS, receiving approval from the IAED in September 2023; in doing so gaining dual accreditation having previously achieved ACE for its Medical Prioritisation Dispatch System (MPDS). It is also notable that the Trust has achieved this through utilising a paramedic and nurse staffing mix (see *objective 4*).

Quality mechanisms: To retain accreditation status, there is a requirement that the Trust audits 132 calls per month¹ and meets a target of 93% call compliance. Compliance is determined through the assessment of a random selection of calls against IAED Performance Standards ('the performance standards'). Key elements of the performance standards have been combined with local guidance and procedural information within a Trust developed ECNS Quality Assurance Framework (QAF).

Concerns regarding the audit process were raised in September 2024 (including the categorisation of non-compliant audits into thematic reporting which were therefore excluded from the compliance total; and increasing audit sample numbers to lower the overall compliance rate). Such practices were immediately stopped (see *objective 5*); however, in the period following this non-compliance increased from 18% in August 2024, to 28% in November 2024, against the ACE target of 7%.

The performance standards also include timescales for feedback to be provided, however capacity constraints within the PPE team (currently 2.8WTE) has resulted in delays in completion, noting December 2024 audits were still to be completed as at April 2025. Whilst the need to review the operational capacity of the PPE team and to appoint dedicated ECNS auditors within an Operations Quality team has been recognised, a timescale was not known at the time of audit fieldwork (See **Key Finding 2**).

Additionally, walkthrough and testing of the audit process identified:

- Enhancement of audit feedback could be enhanced through standardisation of format and terminology (see **Key Finding 3**).
- The schedule which captures clinician performance does not reconcile with the AQUA performance reports (see **Key Finding 4**).
- Audit coverage of clinicians varies across months (See **Key Finding 4**).
- The performance development plan structure as outlined within the QAF is not in operation (see **Key Finding 5**)

¹ The monthly audit requirement is determined by an IAED formula based upon the CSD annual call intake.

Key Findings		Risk & Impact	Agreed Management Action
2	ECNS Audit arrangements Capacity constraints within the PPE team (currently 2.8WTE) has resulted in delays in completion, with December 2024 audits still to be completed as at April 2025, resulting in a backlog in excess of 400 audits. The need to review the operational capacity of the PPE team has been recognised by Integrated Care management, and a business case to secure dedicated ECNS auditors within an Operations Quality team (within the Emergency Medical Service Co-ordination structure) has been approved, although a timescale of implementation was not available at time of audit fieldwork.	Continued lack of capacity to deliver audits could result in loss of accreditation.	Agreed Action: The Trust will have the uplifted number of 6 ECNS auditors in place in Q2 of 25/26 financial year. This uplift will be commensurate with the levels agreed in the business case.
			Expected Evidence of Implementation: The uplifted levels will be evidenced through establishment reports.
		High Priority	Officer: Jonathan Edwards, Assistant Director of Operations Target Implementation Date: 30 th September 25
	Theme: Resourcing	Control Design	
3	ECNS Audit report format Review of audit reports confirmed that they provided a mix of recognition of good practice alongside areas where corrective feedback was required. IAED performance standards notes that when providing feedback there should be focus on the exact performance that did not meet the standard. Our review of 30 audit reports noted that 13 did not reference the performance standard where an issue had been identified; and 17 did not indicate the categorisation of deviation. Currently audit reports are circulated via email to the clinician and line manager, however, there is no requirement for receipt or acknowledgement of content.	Unclear and delayed feedback impact on the value and ability to influence practice of audits.	Agreed Action: Quality Audit realigned to Operations Quality and bespoke job description being created to appoint into permanent Quality Audit (Clinical) posts. Operations Quality to have management and leadership oversight. Levelling to be undertaken to set out expectations for inclusion of all required information such as performance standards and deviation categories and a request to support levelling will be made to the International Academies of Emergency Dispatch (IAED). Consideration will be given more widely on how to ensure monitoring of receipt of feedback and respective managers/local management teams updated.
			Expected Evidence of Implementation: Quality assurance processes will be developed and refined internally, and the IAED Accredited Centre of Excellence (for which the Trust has for ECNS) sets out required standards which will be monitored closely in monthly compliance reports, submitted to the IAED and internally monitored by the Integrated Care Quality Meeting which reports onward into the Senior Operations Team (SOT).
		Medium Priority	Officer: Andrew Garner, Service Manager, Operations Quality

Key Findings		Risk & Impact	Agreed Management Action
	Theme: Performance Monitoring	Control Operation	Target Implementation Date: 31 st December 2025 (this is when the full establishment should be realised following OCP).
4	ECNS Monitoring arrangements The QAF and IAED performance standards include the need for ongoing monitoring of individual clinician performance on a routine basis. A locally held spreadsheet has been developed to support this due to constraints within the AQUA reporting tool and need for cleansing of prior user data. Inconsistencies were noted when comparing this spreadsheet to AQUA generated reports regarding the clinicians included (10 identified as receiving audits but not detailed within the spreadsheet) and the number of audits recorded (only one out of six months totalling the required 132 audits). Additionally, we identified: • six clinicians yet to receive audits, and • on average, 44% of CSD clinicians did not receive an audit each month within our sample period June 2024 – November 2024.	Lack of consistent oversight may result in noncompliance being missed.	Agreed Action: A review will be conducted to move to a single monitoring mechanism with appropriate data cleansing processes. The reporting mechanism will be embedded into Integrated Care Quality Meeting (ICQG) and through the Senior Ops Governance Structure along with CQGG. Those not in receipt of an audit are being prioritised. Expected Evidence of Implementation: AQUA Reporting will be the primary methodology used to report compliance.
		High Priority	Officer: Peter Brown, Assistant Director of Operations Target Implementation Date: 30 th September 2025
	Theme: Performance Monitoring	Control Operation	
5	ECNS Performance Development Plans Where a clinician is identified as 'below a performance threshold' the QAF outlines a performance development plan (PDP) structure to be applied to offer action plans which include additional support, enhanced audits and further escalation where improvement is not achieved. At present, due to the lack of capacity within the PPE team to undertake additional audits, the PDP process is not actively practiced. However, we were advised that local management will engage with ECNS users on wider performance issues. The limitations in coverage and number of clinicians receiving regular audits (see key finding 4) also impacts the effectiveness of the PDP process in identifying those who require additional support.	Lack of mechanisms to address continued noncompliance.	Agreed Action: As per the agreed action for Key Finding 2 the Trust will have the uplifted number of ECNS auditors in place in Q2 of 25/26 financial year. This uplift will be commensurate with the levels agreed in the business case. This will enable the required levels of audits. Expected Evidence of Implementation: The uplifted levels will be evidenced through establishment reports.
		Medium Priority	Officer: Jonathan Edwards, Assistant Director of Operations Target Implementation Date: 30 th September 2025

Key Findings		Risk & Impact	Agreed Management Action
	Theme: Performance Monitoring	Control Operation	

As per *objective two*, in December 2022 the implementation of ECNS was included within the transfer of the outstanding actions from the CCC Clinical Review project to the G2C Programme. G2C highlight reports reviewed listed remaining areas of focus as the use of ECNS functionalities such as video consultations, directory of services and email/text function.

Review of CSD performance dashboards confirms that the use of video consultation within triages has increased in the time since implementation, with the number of such calls rising from under 100 per month at the end of 2022, to between 400-500 video consultations per month between October 2024 – March 2025.

Discussion with key contacts noted that there is continuing progress in utilising other parts of the system, although alternative functionality will be used to communicate call summaries to patients. End of consultation summaries are produced and transferred to the Welsh Clinical Portal for access by wider health services, such as GP Practices or health board urgent care services. We note that fuller integration of ECNS with the clinical portal is a deliverable within the Remote Integrated Care Project; as is continuing to make improvements to the directory of services.

As per *objective one*, the ECNS investment case included forecasts for productivity and financial gains resulting from reductions in call times, however CSD performance reports indicate that these forecast reductions have not materialised. The achievement of such will have been directly impacted by continuing unscheduled care pressures.

We could not identify any subsequent periodic review or reporting on system benefits since the project closed. As such, this, combined with the lack of defined benefits, would mean the Trust is not fully sighted in relation to initial or subsequent achievement. (See **Key Finding 6**)

Key Findings		Risk & Impact	Agreed Management Action
6	Periodic Benefit Assessment We could not identify any post implementation review, or subsequent assessment of the system benefits since the closure of the project. As such the Trust will not be sighted on the system impacts, outcomes and progress towards benefit realisation.	The effectiveness and confidence could be impacted where benefits are not periodically assessed.	Agreed Action: The Trust accepts this finding and agrees with the necessity for clearer benefits assessment milestones at the beginning of such programmes. The majority of benefits were, however, fully realised upon implementation. Consequently, ongoing periodic benefits assessments were not planned. The later rapid addition of 28 full-time clinicians, while helpful, shifted focus and changed baseline operational benefits of other metrics, due to new and rotating CSD staff and demand-capacity adjustments. Operational measures are now monitored through existing mechanisms. The Trust will develop a clear table of evidence outlining which benefits have been achieved on implementation (how and why) and which outstanding benefits require more work or are now being monitored through existing mechanisms or link to existing agreed actions within this audit.

			Expected Evidence of Implementation: Development of a table of ECNS benefits with outline of evidence or monitoring.
		Medium Priority	Officer: Mike Brady, Assistant Clinical Director for Remote Care
	Theme: Performance Monitoring	Control Operation	Target Implementation Date: 30 th September 2025

Objective 4: Lessons learnt have been identified from the programme, including feedback gained through patient and staff experience, to inform immediate and future service changes.

Reasonable

Prior to implementation, representatives of the Trust had published within the *Annals of Emergency Dispatch & Response* journal (an official international peer-reviewed journal published by the IAED) the justification for its use of a paramedic and nurse staffing mix: '*Proposed use of the emergency communication nurse system in Welsh ambulance service 999 secondary triage with paramedic and nurse users*' (2021). This noted that paramedics experience in dealing with a wide range of patient presentation, increasing scope of practice and the Trust's evolving approach to telephone triage which supported this.

The paper included the intention to undertake further research in the period following implementation to explore themes, trends, outcomes and efficiencies; and two further publications have followed – '*Emergency Communication Nurse System Outcomes of Advanced Medical Priority Dispatch Codes in a UK ambulance service*' (2024) and '*999 triage. A comparison of UK ambulance nurse and paramedic case mix, outcomes and audit compliance*' (2024). Both papers were based upon the review of patient data and audits of calls across the period May 2022 – November 2022. The former noted the '*positive range of outcomes reached through secondary consultation*', whilst the latter noted that having assessed patients with the same 'symptomology' there '*was little difference in the clinical outcomes nurses and paramedics reached for their patients and little difference in the overall compliance of their call audits, which were overwhelmingly safe.*'.

As per *objective 3*, no post implementation review has been undertaken following programme closure, the need to ensure adequate capacity for reflection following significant changes was noted in discussion with key contacts. (See **Key Findings 1 & 6**)

At present we note there is no mechanism to allow for patient feedback to be directly collected for ECNS calls, outside of established Trust feedback routes generally available. We are informed the Trust is investigating how it can develop capturing user feedback within the wider Integrated Care service, and feedback received features within monthly Quality Management Group meetings. Staff feedback is captured within the established Integrated Care Quality and Support days, this recently included gathering responses on staff wellbeing, workload and pressures.

Following the implementation of ECNS, a Quality Group was established to identify and review themes and trends, however we could only source documentation for one meeting held in August 2022. We note that, the existing 111 Quality Group was expanded (November 2024) to include CSD under a revised Integrated Care Quality Group (ICQG) remit, with refreshed terms of reference in place to reflect this change, and, discussions with management highlighted awareness that the operation and reporting from the group will need time to mature. The case for investment (see objective one) listed a number of ways in which ECNS data may inform planning and assist in analysis of outcomes, but we were not able to identify that level of analysis within the current reporting arrangements. (See **Key Finding 7**). The CSD ECNS Audit and Quality report provided to the ICQG included an outline of actions to address areas of non-compliance, such as development of supporting guidance to be shared with clinicians, and links to be established with Duty Operations Managers to ensure audit feedback is addressed. However, these actions are not formalised into a plan to address non-compliance rates (See **Key Finding 8**).

The ICQG produces a highlight report following each meeting which is shared with the Operations Directorate Senior Operations Team. There is also a monthly presentation to the Trust Quality Management Group (QMG). Whilst we did not identify either document highlighting the recent issues in completing audits and the increasing non-compliance rate, we were informed that both groups had awareness of the identified issues.

The Operations Senior Leadership Team (SLT) received a report in January 2025 referencing concerns that the prior approach to ECNS audits had obscured the Trust's compliance rate, and this was included within the SLT highlight report to the Trust's Executive Leadership Team. The same SLT meeting endorsed the transfer of audit responsibility to the Operations Quality team within the EMS Co-Ordination, however, further discussion at the March 2025 meeting noted this was still in train (see **Key Finding 2**).

Board-level committees (Finance and Performance, Quality Safety and Patient Experience, and People and Culture committees) regularly receive the Operations Directorate Quarterly Reports (ODQR) which highlight key issues and service developments. Review of the Q2 and Q3 reports (Q4 not reported at completion of fieldwork) did not identify any reference to ECNS non-compliance levels or the possible impact to the Trust's ACE accreditation (see **Key Finding 9**). The Q2 ODQR included that the recent completion of an action plan to address non-compliance within the MPDS has led to the Trust no longer being in remediation status for its accreditation under that discipline.

Within the Trust, the Clinical Prioritisation Assessment Software Group (CPAS) provides oversight for the development of 'clinical guidance and pathways' for both 999 and integrated care. CPAS terms of reference were amended in 2023 to include ECNS and reflect the retirement of the Trust Medical Director who had provided direct oversight during system implementation. Review of CPAS agenda papers noted discussion of ECNS including system issues and updates where applicable.

Key Findings		Risk & Impact	Agreed Management Action
7	ECNS Quality Reporting Whilst we could identify inclusion of activity, compliance rates, and themes included within service quality reports, discussion with officers indicated that these were limited by the relatively small number of audits undertaken per month. Further, we did not identify reporting in line with areas referenced within the investment case which included analysis of: - patient presentation through analysis of previous health interactions - sensitivity of referrals - efficacy of supporting algorithms.	Full functionality and benefits from the system may not be realised within current reports.	Agreed Action: Scheduled to be routinely shared with QMG with the SBAR going to CQGG in May 2025. Expected Evidence of Implementation: SLT minutes, IC Audit and ELT to ELT triple A Report, CQGG SBAR
		Medium Priority	
	Theme: Information, Data Quality & Data Accuracy	Control Design	Officer: N/a Target Implementation Date: Closed post fieldwork
8	Actions to address non-compliance rates The ICQG receives a regular Audit and Quality report in relation to ECNS use within CSD. Noting the reported increase in number of non-compliant calls, the report includes a summary of actions in place to address these. However, whilst status updates were provided for some listed actions, these are not captured formally with associated timescales and leads.	Lack of clarity of action ownership and deadlines may result in improvements not being realised.	Agreed Action: A revised action plan with agreed action owners and timelines will be presented to the June Integrated Care Quality Group with monthly monitoring through that mechanism and reporting through Senior Operations Governance Structure through the AAA mechanism. Expected Evidence of Implementation: ICQG Papers will demonstrate the required detail.
		Medium Priority	
	Theme: Planning, Delivery & Deadline Management	Control Operation	Officer: Peter Brown, Assistant Director of Operations Target Implementation Date: 30 th June 2025

Key Findings		Risk & Impact	Agreed Management Action
9	Reporting to Committee Trust Committees receive regular reporting from the Operations Directorate on key issues and service changes. We note committee reporting has not included the issues currently faced in addressing ACE accreditation compliance rates in respect of ECNS, and the potential risk that this accreditation may be lost.	Lack of escalation may leave the Trust unsighted on a reputational risk.	Agreed Action: Committee reporting for Q4 2024/25 includes the issues currently faced in addressing ACE accreditation compliance rates in respect of ECNS.
			Expected Evidence of Implementation: Operations Quarterly Report (Q4 provided to QUEST 9 th May 2025)
		Medium Priority	Officer: N/a
Theme: Reporting		Control Operation	Target Implementation Date: Closed post fieldwork.

Appendix A Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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Capital Systems

Final Internal Audit Report

2024/25

Welsh Ambulance Services University NHS Trust



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	4
Appendix A: Assurance Opinion & Prioritisation of Findings.....	11

Review Reference

WAS-SSU-2425-19

Fieldwork

March – May 2025

Executive Sign Off

12 June 2025

Audit Committee

24 June 2025

Executive Lead

Chris Turley, Executive Director of Finance & Corporate Services

Audit Team

Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

Executive Summary

Purpose

This audit was commissioned in accordance with the agreed 2024/25 Internal Audit Plan. Capital systems coverage focused on the selection, appointment and contractual arrangements applied at Capital and Estates projects.

Overview

We have concluded that this area offers **reasonable** assurance. Whilst good compliance was noted in most areas of the expected control environment for projects, the following matters were identified for management attention:

- Capital procedures: whilst there are a number of processes in place to support the progression of a capital project from inception to closure they are not formally documented, the detail of which (and the expectations for key document retention) would enable consistency and standardisation of approach.
- Declarations of interest and non-collusion: retention of evidence for the affirmation of such.
- Contract documentation: a signed contract for one of the projects was not yet in place; however, the purchase order had been actioned on Oracle with work also having been commenced on site. Further, for those signed contracts, the contract amendments had not been annotated as accepted by both parties. Where the contracts had been signed, there is an expectation that all pages containing amendments to the standard form contract are annotated as accepted by both parties; however, this was not evidenced.
- Contract retention period: whilst complying with the NHS Wales Records Management Code of Practice 2022, the retention period is not sufficient to cover the liability period for contracts executed as deed.

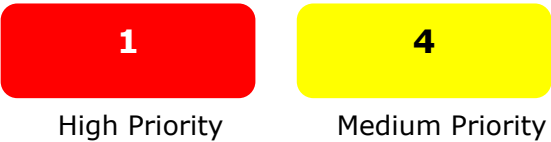
Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

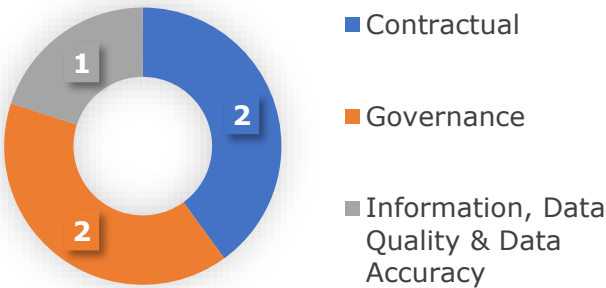
Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion		Related Findings	Assurance
1	Governance - to assess the application of appropriate procurement policies and procedures to Capital and Estates contracts and ensure that roles and responsibilities and approval requirements were adequately defined.	1	Reasonable
2	Selection and Appointment – to ensure the appropriate application of Standing Orders, Standing Financial Instructions (SFIs), national and local procurement policies for the selection and appointment of contractors and technical advisers. To ensure the application of appropriate competitive tender/quotation arrangements, the use of frameworks (as applicable) and the appropriateness of associated management and reporting.	1, 2	Reasonable
3	Value for Money and Award – to ensure that there was an appropriate assessment of value for money (e.g. via tendering/ quotation, benchmarking etc), with formal recommendations for award. Appropriate approvals were in place, that fully considered the above and any associated limitations.	-	Substantial

4	Contract Completion – to obtain assurance on the timely completion, recording, and approval of agreement/ contract versions in accordance with the approved contract strategy (with appropriate inclusions and clauses).	3 ,4	Reasonable
5	Retention of contract and project documentation - to obtain assurance that Capital and Estate’s contract information was retained for the requisite period (in accordance with national guidance) and that all contract documentation was held securely.	5	Reasonable

Management Actions



Themes



Risk Types

- Financial Loss
- Legal & Regulatory Non-Compliance
- Public Perception & Reputational Risk

Capital Systems - At a Glance

The following five projects were sampled for this audit covering a range of values and funding sources as follows:

Project title	Year	Contract Value (£)	Funding Mechanism
Llangunnor Clinical Control Centre Works	2024/25	£664,743.96	Discretionary Capital Projects (DCP)
Newtown Ambulance Station: refurbishment	2024/25	£349,452.31	Estate Funding Advisory Board (EFAB)
Pontardawe Ambulance Station: refurbishment	2024/25	£253,269.85	Estate Funding Advisory Board (EFAB)
Blackwood Ambulance Station: re-roofing works	2024/25	£145,568.74	Discretionary Capital Projects (DCP)
EV Charging Infrastructure – Rapid Charging	2024/25	£96,669.16 ¹	Discretionary Capital Projects (DCP)

¹ At the date of audit fieldwork, a signed contract was not available for review.

Findings & Agreed Action Plan

Objective 1: Governance		Reasonable
The Trust has adopted the NHS Model Standing Financial Instructions and Standing Orders, Reservation and Delegation of Powers, with the latest amendment made in September 2023. Section 15 of the Standing Financial Instructions addressed the detail for <i>Capital Plan, Capital Equipment, Fixed Asset Register and Security of Assets</i>, with reference provided to Welsh Government requirements and guidance for capital investment decisions (NHS Wales Infrastructure Investment Guidance and development of business cases (Better Business Cases: investment decision making framework). Section 15.4 references capital procedures and responsibilities with section 15.4.7 stating that <i>the Executive Director of Strategy, Planning and Performance and Executive Director of Finance and Corporate Resources shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers’ guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered. The Executive Director of Finance and Corporate Resources shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.</i> However, there was no evidence of such documented procedures being in place at the Trust (see Key Finding 1). We were advised that the management of projects is by following the RIBA (Royal Institute of British Architects) stages through Prince2 methodology, and note that a recent presentation (October 2024) as part of a Capital team away day reiterated such providing reference to such stages which addressed the core tasks applicable to each project. However, this does not address the process prior to approval. It may be worth considering the introduction of a project checklist, which we have evidenced at other NHS Wales organisations, which would provide the high-level guidance to proceed with a project.		
Key Findings		Agreed Management Action
1	Capital Procedures Whilst there are a number of processes in place at the Trust to support the progression of a capital project from inception to closure, they are not formally documented. It is acknowledged that the principles of Prince 2 methodology are applied, and guidance has been provided in relation to the core tasks applicable within each of the RIBA stages. We have evidenced at other NHS organisations the application of a project checklist for completion as each stage of the project progresses; and such could be extended to include expectations for receipt of key documentation such as: • declarations of interest, collusion certificates (see objective 2), • confirmation of parent company guarantees (if applicable), • insurance documentation and the minimum coverage amounts based on project size and risk; • confirmation that the successful / unsuccessful award notifications have been issued to the contractors.	No procedural standards exposing the Trust to regulatory or reputational risks.
		Proposed Management Action: Develop project checklist for adoption by all schemes (and tailored accordingly to each as required).
		Expected Evidence of Implementation: Project checklist issued to Project Managers for adoption within project documentation.
		Officer: Head of Capital Development Date: 30 September 2025
		Medium Priority

	Theme: Policies & Procedures	Control Design	

Objective 2: Selection and Appointment

Reasonable

For the five sampled projects at this review, the Trust with the support of NWSSP Procurement Services completed a competitive tendering exercise, managed through the digital platform of Sell 2 Wales. Compliance was noted with the Standing Financial Instructions (section 11.11.1) for procurement between £25k and £1m for all.

Within our sample of projects, pre-tender estimates had been prepared prior to market testing and these costs were included within the submission to the Internal Capital Monitoring Group for consideration for funding route. This is seen as positive practice and contributes to the setting of realistic financial expectations and facilitating effective financial planning.

Following market testing, technical and financial vetting was conducted to ensure that all potential contractors met the necessary standards and addressed the respective project's specification of works. This vetting includes organisational details, capability, financial, insurance, disputes, declaration of good standing and other relevant information. These measures are key to mitigating risks and ensuring that only qualified and compliant contractors are considered. Formal Contract Award Recommendation Reports (CARR), detailing the evaluations undertaken and the recommendations for awarding contracts, were prepared and signed off by an appropriate officer within the Trust. This process ensures transparency and accountability on the decision-making process.

Challenge was observed on the occasion when the tender analysis identified a higher value than budget (Newtown Ambulance Station), and recommendation was made to revise the tender awarded accordingly; with appropriate evidence retained of the value engineering exercise that was undertaken by the interested contractors.

Whilst the evaluation has been undertaken by the NWSSP Procurement officers, in consideration of the agreed evaluation requirements set at the tender stage, there was no evidence to confirm their independence of the contractors detailed within the report (see **Key Finding 2**). Trust Senior staff (band 8a and above) confirm annual declarations of interest; and there is an expectation that reaffirmation is sought before involvement in procurement exercises – with confirmation also sought for those project officers who would fall outside of the annual declaration process. Such is provided to NWSSP Procurement Services as part of the tender exercise.. From review of the contract award recommendation reports, where there are issues of concern, such will be flagged (and it was noted there were no such instances of compromise identified for the sample selected). However, there would be benefit in ensuring all completed declarations are retained / referenced centrally by the Trust (see **Key Finding 1**).

Further, there was no evidence of a declaration of non-collusion having been completed by the contractor upon return of their tender documentation (see **Key Finding 2**). Whilst appreciating that such may be held by NWSSP Procurement Services team, for completeness, reference to such could be incorporated into the CARR or a project checklist (see **Key Finding 1**)

Key Findings		Risk & Impact	Agreed Management Action
2	Declarations of interest / non-collusion There was no evidence to confirm independence from the contractors submitting tenders by the NWSSP Procurement officers involved in the procurement exercises. Further, there was no evidence of a non-collusion form having been completed by the contractor upon return of their tender documentation. Management advised that the commercial, technical and financial information received from contractors will not be released unless affirmations of independence have been received (the same being applicable in respect of non-collusion). However, in the instances of the four signed contracts reviewed,	Financial or reputational risk heightened by entering contracts with organisations from which independence has not been affirmed.	Proposed Management Action: Project Managers to hold a copy of completed DOIs returned to NWSSP before tender submissions are released for scoring. This will be recorded on the project checklist. Provide a copy of the Internal Audit report to request NWSSP Procurement confirm in writing that they will fulfil their requirements in respect of ensuring due independence / governance in all future procurement. Further to include in the Procurement Outcome Report (POR); previously the CARR, the necessary confirmation of independence by all NWSSP officers involved in the process and receipt of non-collusion forms.

	NWSSP Procurement confirmed the officers were not asked, therefore lessening this 'control'.		Expected Evidence of Implementation: Project checklist updated by Project Managers to reflect retention of Trust DOI forms. Email to provide Internal Audit report to NWSSP Procurement with a request that they update the POR as per the findings of the audit report and provide written confirmation of independence and confirmation of non-collusion forms.
	Theme: Governance	High Priority Control Operation	Officer: Head of Capital Development and Deputy Head of Procurement Date: 30 November 2025

Objective 3: Value for Money (VfM)	Substantial
As per the Standing Financial Instructions, section 11.10.3 states <i>agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for Money is defined as the optimum combination of whole-life cost and quality to meet the requirement.</i> For each of the projects sampled at this review, the supporting CARR clearly stipulated that such were to be awarded on the basis of the most economically advantageous tender. This was evidenced for all following completion of both the technical and commercial evaluation of the tenders received.	

Objective 4: Contract Completion

Reasonable

From the five projects sampled, at the date of audit fieldwork, four had contracts in place which had been signed in accordance with the Trust's Scheme of Delegation; with purchase orders appropriately actioned on Oracle. Through our audit work, we look for assurance that the contracts were signed before commencement of works. We noted that none of the signed contracts were dated but appreciate there is no request for a date on the face of contract; and the compensatory control is that the purchase order is approved in advance of commencement of works (as confirmed through review of Oracle) and no pre-contract start meeting is held with the appointed contract prior to approval of the purchase order. Therefore, we have not sought to raise a finding at this report.

All contracts were executed as a deed, irrespective of financial value or project complexity. This approach ensures robustness and enforceability noting the liability periods extend to 12 years, from 6 years, when contracts are executed "under hand".

The contract for the EV Charging Infrastructure, whilst confirmed as the decision to appoint being approved in the CARR, was not available. Management advised that the successful contractor had been provided with the required documents for signing but such had yet to be received (see **Key Finding 3**)

JCT Contracts have been used for all – two being *Minor Works Building Contracts*; and two being *Standard Building Contracts without Quantities 2016*. All include delay damages clauses with such ranging from £500 to £1,500 per week; with a correlation between the value of the contract and the respective value of delay damages provided. Contracts clearly identified details such as key dates, agreed price, rectification period, payment terms and contractor's Public Liability insurance value.

Whilst the contracts have been signed, there is an expectation that pages/changes to the standard form contract are annotated by both parties accepting the changes specific to the respective project. This was only evidenced for one contract: Pontardawe Ambulance Station (see **Key Finding 4**)

Key Findings	Risk & Impact	Agreed Management Action
3 Completion of contract documentation The finalised contract for the EV Charging Infrastructure was not available for review at the date of audit fieldwork. From review of the EV Project Board minutes, that at the date of fieldwork completion, two of the three charging stations had been installed. At the date of this report, we note that all work has been completed. We understand that the signed documentation is currently being chased by both the Trust and NWSSP Procurement Services for finalisation, but such should be in place prior to actioning the purchase order on Oracle (which we noted had been done), including evidence of parent company guarantee (see Key Finding 1). The appointment was made following a mini competition from the ESPO Vehicle Charging Infrastructure (VCI) Framework–financial risk reduced with the purchase order placed on Oracle; but from a service delivery perspective, should issues be encountered post completion, there is no contractual documentation to support responsibility. Theme: Contractual	In the absence of a formal contract, the Trust lacks legal recourse if a contractor fails to meet agreed deliverables, causing potential financial loss or project delays. Medium Priority Control Operation	Proposed Management Action: Continue to chase the signed Framework Agreement for the EV Charging Infrastructure work. Expected Evidence of Implementation: Evidence of chasing and/or signed Framework Agreement. Officer: Capital Programme Manager Date: 30 September 2025

4	Annotation of contracts All of the four contracts reviewed are standard JCT contracts. Amendment to the standard form i.e. inclusion of values, dates, delay damages etc should be annotated (page by page) so as to demonstrate acceptance by both parties; in addition to the expected formal signing of the contract. However, this was only evidenced for one contract noting this had been applied due to an error in the contractual value that had been recorded.	Different contract terms in place should a challenge, claim or dispute arise – weakening the position of the Trust.	Proposed Management Action: Cost Advisor to highlight specific detail included in the standard JCT contract. Changes to be annotated a point of signature.
	Theme: Contractual	Medium Priority Control Operation	Expected Evidence of Implementation: Example of a signed JCT contract with changes annotated. Officer: Executive Director of Finance & Corporate Resources and Board Secretary Date: 30 April 2026

Objective 5: Retention of Documents

Reasonable

Project documentation, including contract information, is retained in accordance with the Trust's Records Management Policy which cites that the *retention schedule is to be applied as per the NHS Wales Records Management Code of Practice 2022*. As per the Code of Practice, *contracts sealed or unsealed – retain for 6 years after the end of the contract*.

Of the signed four contracts that were available at this review all have been executed as deed (see objective 4). Contracts executed as deed conveys longer liability periods for 12 years, or the useful life of the associated building(s) (or their disposal). The guidance provided in the Code of Practice, therefore, is inadequate (see **Key Finding 5**), Whilst management advised that contract documentation is retained for the life of the building, this is not cited within a policy / procedure.

We noted that the Trust has initiated the development of an organisational contract register. The contracts which have been sampled at this review (which are currently included within a dedicated Capital Contracts listing) were not included on the organisational register but we acknowledge that the completion of the register remains ongoing at the date of audit fieldwork. Noting that this point is being raised at the wider Contract Management audit (advisory), including enhancements to provide a clearer picture of contract performance, we have not sought to replicate a recommendation/action at this report.

We were advised that all contract documentation is held securely – both electronically, with defined access; and physically, at the Carmarthen office with appropriate security control in place.

Key Findings		Risk & Impact	Agreed Management Action
5	Contract Retention Period The four contracts that were available at this review were executed as a deed, which conveys longer liability periods of 12 years or the useful life of the associated building/s (or their disposal). Accordingly, the proposed retention period of six years is insufficient.	Financial or performance-based loss could be incurred by the Trust due to lack of evidence of contract-based mitigation.	Proposed Management Action: All contract documentation stored in the Operating & Maintenance (O&M) manual structure and noted on the project checklist. Internal Audit report to be provided to Records Management Team with request that the next update to the Trust's Record Management Policy recognises compliance with the NHS Code of Practice but provides additional confirmation of the process to be applied for contracts executed as deed.
			Expected Evidence of Implementation: Screenshot of JCT contract held in O&M folder for scheme completed (2024/25 schemes for purpose of evidence). Evidence of Internal Audit report provided to Records Services and Archives Manager.
	Theme: Information & Data Management	Medium Priority Control Design	Officer: Head of Capital Development Date: 31 July 2025

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
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	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
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Priority	Explanation
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Audit, Risk and Assurance Committee Update – Welsh Ambulance Services University NHS Trust

Date issued: June 2025

Document reference: 4959A2025

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Contents

Audit, Risk and Assurance Committee update:

About this document	4
Accounts audit update	5
Performance audit update	6
Good Practice events and products	7
NHS-related national studies and related products	9
Additional information	9

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 detailed 2025 Audit Plan to the committee on 1 May 2025.
- 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
Audit of the Trust's 2024-25 Financial Statements	Executive Director of Finance and Corporate Resources	The audit certification deadline for the 2024-25 accounts is 30 June 2025 which is two 2 weeks earlier than last year. We received the 2024-25 draft accounts and annual report in accordance with the submission timetable. Audit fieldwork is nearing completion. The Audit of Accounts Report will be presented to the Audit Risk and Assurance Committee on 24 June 2025, with Board approval of the Trust's financial statements to follow on 26 June 2025. The Auditor General is scheduled to certify the financial statements on 27 June 2025 ahead of the 30 June 2025 deadline.

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
Review of Unscheduled Care	Executive Director of Operations	This work examined 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: Complete Part Three: Complete	June 2025
Structured Assessment - deep dive review of investment in	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	Project Brief issued	November 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
digital systems to support service resilience and transformation		workforce, transform patient care, meet demand, and improve productivity and efficiency.	Fieldwork due to begin June 2025	
Structured Assessment 2025 - core	Board Secretary / Director of Corporate Governance	The 2025 structured assessment work will review the following areas: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements. This year's work will also include a review the Trust's arrangements for setting its wellbeing objectives.	Project Brief issued.	November 2025
Structured Assessment 2025 – review of the	Executive Director of Finance and	This review will examine the effectiveness of the Trust's corporate arrangements to manage its estate with a particular focus on how NHS bodies are prioritising resources	Not yet started	March 2026

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
arrangements to manage estates	Corporate Resources	to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.		
Review of Non-Emergency Patient Transport Service	Executive Director of Operations	This review of the Trust's Non-Emergency Patient Transport Service will examine the effectiveness and efficiency of the service, with a particular focus on arrangements for the transfer and discharge service within this area of the organisation. The specific scope of this work will be determined and discussed with officers in the Trust over the coming months.	Not yet started	March 2026

Audit Committee Update

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
<u>Cost Savings Arrangements: A Checklist for NHS Board Members</u>	June 2025
<u>No time to lose: Lessons from our work under the Well-being of Future Generations Act</u>	April 2025
<u>The Biodiversity and Resilience of Ecosystems Duty</u>	March 2025
<u>Addressing workforce challenges in NHS Wales</u>	February 2025
<u>Cancer services in Wales</u>	January 2025

Additional information

- 7 **Exhibit 4** provides information on corporate documents recently published by Audit Wales. 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
<u>Annual Plan 2025-26</u>	April 2025

Title	Publication Date
<u>Fee Scheme</u>	January 2025
<u>Audit Quality Report 2024: Strengthening trust in audit</u>	January 2025



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

Urgent and Emergency Care – Arrangements for Managing Demand Welsh Ambulance Services University NHS Trust

Date issued: April 2025

Document reference: 4820A2025

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

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Contents

About this report	4
Key facts and figures	5
Key messages	7
Recommendations	9
Detailed report	
Planning arrangements	10
Accessing services	13
Scrutiny and monitoring arrangements	24
Appendices	
Appendix 1 – audit methods	28
Appendix 2 – audit criteria	30
Appendix 3 – management response	33

Summary report

About this report

- 1 This report sets out the findings from the Auditor General's 2024 review of the arrangements for managing demand for urgent and emergency care at the Welsh Ambulance Services University NHS Trust (the Trust). The work is the second phase of a programme of work focused on several elements of the urgent and emergency care system in Wales. The first phase, which examined discharge planning and the impact of patient flow on urgent and emergency care, has been reported separately in regional reports covering the health board and local authorities for each of the seven health and social care regions¹.
- 2 Our approach recognises that the urgent and emergency care system is complex, with many different organisations needing to work together to provide urgent and emergency care and to ensure the wider system works effectively and efficiently. The Welsh Government's [Six Goals for Urgent and Emergency Care Programme](#) (Six Goals Programme) launched in 2021, provides the context for our work. At the time of our review, the urgent and emergency care system in Wales continues to be under significant pressure.
- 3 Our work has examined how the Trust is managing demand for urgent and emergency care services. Specifically, we looked at how it is working to reduce conveyance to Emergency Departments and how it supports the treatment of patients in the right place, first time for their needs, where better alternatives to attendance at Emergency Departments exist. The work has been undertaken to help discharge the Auditor General's statutory duties under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Trust has proper arrangements in place to ensure the efficient, effective, and economic use of its resources.
- 4 We undertook our work between May 2024 and January 2025. The audit methods and criteria we used to deliver our work are summarised in **Appendix 1 and 2**.

¹ The seven health and social care regions align with the seven regional partnership boards.

Key facts and figures

Calls to 111 and 999

2,427	Average number of calls to the 111 service every day in February 2024 ² (101 calls an hour).
14%	Calls to 999 that were ended following a WAST telephone assessment (providing advice or signposting to alternative services) in February 2024 ³ , compared to 8.2% in February 2019
178%	Increase in Category A (red) ambulance calls between February 2019 and February 2025.
15%	999 callers who cancelled their ambulance or were told that the Trust could not send an ambulance to them during February 2025, compared to 24% in November 2024.

Ambulance response

51%	Category A (red) ambulance calls responded to within eight minutes in February 2025, compared to 72% in February 2019. The national target is 65%. ⁴
02:03hrs	Average response time to amber calls in February 2025, an increase of 1 hour 37 minutes compared to the average in February 2019.
63%	Patients conveyed to hospital following a 999 call in February 2025, compared to 68% in February 2019.

² Due to the Trust implementing a new 111 system for call handling and clinical assessment there has been disruption to the reporting of this data since February 2024.

³ This verified data is currently only available up to April 2024, however February 2024 data used for comparative purposes.

⁴ As described in paragraph 55 the level of demand and the number of patients the Trust is reaching within eight minutes is growing.

Handover delays

16%	Patients handed over from ambulance crews to an emergency department within 15 minutes of arrival in February 2025, compared to 53% in February 2019 and against a national target of 100%.
1,601	Number of patient handovers which took longer than 4 hours in February 2025.
18,812	Lost hours due to handover delays in February 2025, compared to 5,610 lost hours in February 2019. This is an increase of 235%.
463	Patients estimated to be coming to severe harm because of long handover delays in February 2025 ⁵ . This equates to 3.5% of total handovers.

Funding

£0	Direct allocation of Six Goals Programme funding.

⁵ Based on [modelling developed by the Association of Ambulance Chief Executives](#), 2021

Key messages

Overall conclusion

- 5 Overall, we found that **changes to service delivery are leading to improvements in managing urgent and emergency care demand, supported by clear and regularly monitored plans. However, their impact is hindered by limitations in joined up data and access to alternative pathways in health boards as well as by continually high levels of handover delays at Emergency Departments.**

Key findings

Planning arrangements

- 6 The Trust has robust and clear plans for managing urgent and emergency care demand, with changes aimed to better manage demand by treating patients in the community rather than taking them to hospital, where possible.
- 7 Plans are informed by data and seek to address the risks associated with urgent and emergency care with actions that are aligned to the Six Goals Programme. The Trust does not have direct access to national six goals funding in the same way as health boards. As a result, the Trust is largely reliant on identifying sources of, and bidding for, national allocations to enact service changes it believes could improve patient safety and experience, which has caused plans to be deferred or delayed in recent years. However, the Trust has prioritised the uplift in allocation to progress plans to transform its clinical model in an attempt to mitigate avoidable harm within its control.

Accessing services

- 8 The Trust employs a range of methods to provide members of the public with information on its urgent and emergency care services. Although there is no communication plan, the Trust has recently updated its engagement plan to support its Clinical Model Transformation Programme. The Trust uses methods including social media posts and public engagement events to engage with and inform the public about using urgent and emergency care services. However, there are no mechanisms in place to assess and monitor the public's understanding of its services and when these should be accessed.
- 9 The Trust is aware of ongoing issues with the 111 Wales website, including the symptom checker. While small improvements are being progressed to address immediate functionality concerns, a draft business case has been developed to support more substantial improvements. The symptom checker tool is currently signposting users to out-of-date information which the Trust recognises as a priority issue. The Trust has agreed to use discretionary capital funding to begin

work on updating the symptom checkers, with further funding to support comprehensive improvements included in the drafted business case currently under discussion with commissioners.

- 10 Over recent years, the Trust has expanded the range of services it offers, including expanding its clinical desk, developing additional specialist practitioners and increasing its use of advanced paramedic practitioners. These are having a positive impact on managing urgent and emergency care demand. Rates of providing remote advice to patients have risen since pre-pandemic levels, with early data indicating that there are further improvements since the Trust changed its clinical model in November 2024. As a result, more patients are being treated over the phone and less are being conveyed to hospital.
- 11 However, the Trust's ability to redirect patients is also reliant on the availability of alternative services in health boards. While referrals to the GP out of hours services are increasing, referrals to alternative services remain low. The Trust holds a directory of services for each health board area, but these are not always accurate and up to date. Issues accessing alternative pathways by Trust staff, including Urgent Primary Care Centres and Same Day Emergency Centres also means that conveyance to an Emergency Department often remains the default destination when remote or face-to-face clinical assessment have identified an ongoing healthcare need for the patient.
- 12 The benefits of the service changes made by the Trust also continue to be outweighed by the continuing problems with long handover delays across Wales. Only 16% of patients were handed over from ambulance crews to an Emergency Department within 15 minutes of arrival over the last twelve months, compared to a national target of 100%. Response times for both red and amber calls continue to be challenged, with risks that both delays in response times and handover delays are resulting in patients coming to harm. Lack of available ambulances is likely also leading to higher attendance rates at emergency departments across Wales, as patients make their own way to hospital. Some of these patients may not have needed to go to the emergency department, but opportunities for paramedics to treat patients remotely (See and Treat) earlier in their patient journey are being missed due to handover delays.

Scrutiny and monitoring arrangements

- 13 The Board and operational groups regularly monitor and scrutinise the progress of plans and their impact on mitigating avoidable patient harm and operational risks.
- 14 There is a range of data to monitor and scrutinise how the Trust's service changes are working. However, this data is not joined up with health board data, which limits the Trust's understanding of how its services impact on the entire patient journey, though the Trust is currently working to find solutions to this issue. The Trust is capturing staff and patient feedback, which it feeds into its future strategic plans, but response rates are low.

Recommendations

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

Exhibit 1: recommendations

Recommendations	
Accuracy of 111 Wales website	
R1	To ensure information used to signpost patients to urgent and emergency services are accurate, the Trust should work with partners to review and replace any out-of-date or misleading information on the 111 Wales website, for example, the NHS Direct Wales phone number (Paragraph 27).
Directories of Service	
R2	To ensure the Trust has access to accurate and up-to-date information on health board services it should work with health boards to identify leads for maintaining the directories (Paragraph 45).

Detailed report

Planning arrangements

- 16
- This section considers whether the Trust has robust plans in place to manage the demand on urgent and emergency care services. We were specifically looking for evidence of plans:
- being informed by relevant and up to date information;
 - identifying and seeking to address key risks associated with urgent and emergency care services;
 - aligning with requirements of the Six Goals Programme, and clearly setting out how alternative clinical pathways will work; and
 - identifying the current and required levels of resource and staffing to achieve the intended ambitions.
- 17
- We reviewed the Trust’s Integrated Medium-Term Plan (IMTP) along with its longer-term strategic framework, its plans relating to its Clinical Model Transformation Programme⁶ developed during 2024, and its winter plan for 2024-25.
- 18
- We found that **plans for managing urgent and emergency demand are robust and clear and clearly align to the national Six Goals Programme.**
- 19
- The findings from our review of the plans are summarised in **Exhibit 2.**

Exhibit 2: approach to planning urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Plans are informed by relevant and up to date information?	Yes	The Trust’s plans contain relevant and up-to-date information, including operational performance, demographic predictions and demand and capacity data. They also include modelled scenarios for the Trust’s performance, based on actual and potentially improved levels of handover

⁶ The Clinical Model Transformation Programme is a programme of work the Trust is leading, with the support of commissioners and partners. The programme seeks to increase clinical input within the patient call cycle and to provide a greater range of response options for patients who need a face-to-face assessment. These changes should enable more patients to access treatment appropriate to their needs without the need for a hospital conveyance.

Audit question	Yes/ No/ Partially	Findings
		delays experienced within the broader health system.
Plans identify and seek to address key risks associated with urgent and emergency care services?	Yes	The Trust's plans clearly identify key risks and mitigating actions. Risks align with those identified through the Trust's corporate risk register. These risks focus on the impact of operational pressures on the Trust's ability to provide a safe service for patients. These risks have been at the highest score of 25 since December 2019 due to ongoing and increasing pressures. The Trust is currently engaged in a programme of work which includes a review of these risks to delineate between what can be managed and mitigated by the Trust and what external factors the Trust can monitor and seek to influence. Risks in relation to specific service changes and projects are also identified and regularly overseen by operational groups, with concerns escalated to the Trust's Strategic Transformation Board.
Plans align with requirements of the <u>Six Goals for Urgent and Emergency Care Programme</u> , and clearly setting out how the alternative clinical pathways will work?	Yes	The IMTP is explicit about its alignment to the Six Goals Programme and demonstrates how the Trust can make a meaningful contribution across each individual goal. Appendix 1 of the IMTP clearly articulates each goal, the relevant quality statement, the actions the Trust intends to take to achieve each goal and what it anticipates being the measurable benefits of its actions. Relevant sections throughout the body of the IMTP detail how alternative pathways or service improvements will work. The IMTP, along with the documents on the clinical model transformation programme outline changes aimed to better manage demand by treating patients in the community rather than taking them to hospital, where possible. These include introducing rapid

Audit question	Yes/ No/ Partially	Findings
		clinical screening for 999 calls to identify potential opportunities to signpost them to alternative services, expansion of Advanced Paramedic Practitioner roles and enhancing falls services.
Plans identify the current and required levels of staffing and resource to achieve the intended ambitions?	Partially	The IMTP has clear implications for increasing the workforce in specific service areas. Plans to support these implications are further detailed within the Trust's strategic workforce plan. The IMTP does not clearly identify the costs required to pursue additional schemes, and whether they require additional funding. However, this detailed information is available within the Trust's more detailed financial plans. The Trust does not receive a direct allocation of Six Goals funding in the same way as health boards, though it can access funding via the health boards to contribute to specific health-board schemes. The limited availability of additional funding has led to the Trust needing to slow the pace or defer planned changes to some of its services in recent years. However, in line with other NHS bodies, the Trust received an uplift in its core allocation during 2024-25, which enabled it to progress its clinical model transformation programme.

Source: Audit Wales

Accessing services

- 20 This section considers whether the Trust has appropriate arrangements in place to encourage and enable people to access urgent and emergency care services that best meet their needs, and whether these arrangements are working. We were specifically looking for evidence of:
- effective signposting of patients to the most appropriate urgent and emergency care services;
 - staff having access to good information on the range of services available to patients, and the extent to which there is good engagement between Trust and health board staff involved in urgent and emergency care;
 - a range of services that help manage urgency and emergency demand; and
 - whether the above arrangements are helping to positively manage demand for urgent and emergency care services.
- 21 We found that **the Trust's approach to managing demand is improving, but handover delays limit the operational efficiencies gained from improvements, and information on the entire patient journey is not joined up.**

Signposting of services to the public

- 22 We found that **activity to signpost information to the public is not evaluated to ensure it is effective, and there are ongoing issues with the 111 Wales website.**

Communication plans

- 23 The Trust does not have a communication plan which sets out how it engages with the public to improve and support their understanding of how to access urgent and emergency care services. However, the Trust has recently updated its Engagement Plan, originally developed in 2023, to support its Clinical Model Transformation Programme which includes information on public messaging. However, the engagement plan is very high-level and does not outline the details of its approach to public engagement.
- 24 The Trust employs a range of methods to provide members of the public with information on its urgent and emergency care services. These methods include social media posts, news coverage in times of significant pressure, and information contained on the Trust and 111 Wales websites. Through its Public Engagement and Community Involvement Team, the Trust also holds events to engage with the public. According to an internal audit report in February 2025, this team held 147 events between January 2023 and October 2024 where it met with a variety of community groups. As part of these events the Trust will inform patients which services they should access and when.

111 Wales website

- 25 The 111 Wales website describes itself as ‘the home of health advice and information for people living in Wales’ and is a key tool to signpost the public to healthcare options. It includes symptom checkers, information on what to do out of hours, a directory of nearby services and advice on planned care and living well. The number of website hits on the 111 Wales website increased significantly during 2023. Currently an average of 400,000 – 550,000 people access the 111 website each month across Wales.
- 26 Available data does not show the main reasons people visit the 111 Wales website, but there is data on the main reasons for people calling the 111 phoneline. The top five reasons for calls are set out in **Exhibit 3**.

Exhibit 3: top five reasons for calling 111 (February 2024)

All-Wales position	% of all calls
Dental problems	4.1
Abdominal pain	2.4
Chest pain	1.6
Cough	1.4
Rash	1.0

Source: Ambulance Services Indicators

- 27 We reviewed the 111 Wales website symptom checker to understand what advice is available to patients searching for help on the most common conditions. We found that the website can be unreliable, with the symptom checker sometimes failing and displaying an error message. Our tests of the symptom checker showed that it can also refer the user to out-of-date information, including the old NHS Direct Wales number (**Recommendation 1**). Furthermore, our review found that the skin rashes tool has limited functionality, consisting of a slideshow of images. The Trust routinely seeks feedback from the public via an online survey to understand their experiences of the 111 Wales website. Past feedback from the public has raised similar issues with the functionality of the symptom checker and the website more generally.
- 28 The Trust is aware of ongoing issues with the symptom checker and recognises the need for increased investment in the website. While small changes are being made to improve its functionality and user experience, the Trust has also invested in the development of virtual assistant technology during 2024-25, which was ongoing at the time of our fieldwork. To address wider challenges, the Trust has drafted a business case to support more substantial changes to the website,

including updated symptom checker functionality and enhanced governance of the digital front door. The business case will be submitted to commissioners and the national Six Goals Programme Board following discussions with Welsh Government regarding financial envelopes and commissioner expectations. The business case will also cover 111 communications activity, and as this work progresses, the Trust should ensure it includes mechanisms to evaluate the effectiveness of its public engagement and adapt its approach where needed.

Staff awareness and ability to refer

- 29 We found that **referral pathways and processes between the Trust and health boards do not work seamlessly which is impacting access to alternative services.**

Assessment and treatment

- 30 During the last ten years, the Trust has introduced many initiatives and service changes to enhance its clinical offering with the aim of increasing the treatment of patients within the community and reducing conveyances to hospital. This has included expanding its clinical desk to provide advice to patients over the phone to 999 callers as well as introducing a referral process for patients seeking mental health support to have fast and direct access to relevant health board services (referred to as '111 press 2'). The Trust has also invested in its ability to treat patients face-to-face within the community, enabling them to stay at home, including increased its advanced paramedic practitioner workforce.
- 31 The ability of the Trust to treat, provide advice or signpost information to patients to avoid conveyance to hospital is referred to as 'consult and close'⁷ and 'see and treat.' **Exhibit 4** sets out the extent to which the ambulance call centre can manage patients after assessment (consult and close), and ambulance crews can manage patients at the scene (see and treat).

⁷ Previously referred to as 'hear and treat'.

Exhibit 4: percentage of ambulance calls and responses ended after telephone assessment (May 2023 – April 2024) or at scene (May 2023– April 2024) ⁸

Indicator	All-Wales position	Trend
% of ambulance 999 calls ended after telephone assessment (consult and close)	13.9	
% of ambulance responses treated at scene (see and treat)	12.1	

Source: Ambulance Service Indicators

- 32 The rate of consult and close has increased substantially in recent years, from 8.2% in February 2019 to 14% in February 2024. This increase is mainly due to an increasing investment in recruiting clinicians to operate its Clinical Support Desk, particularly as part of plans to mitigate annual winter pressures.
- 33 Recent unverified data shows that the number of patients treated or referred to alternative services over the phone is further increasing after the Trust introduced rapid clinical assessments. In 2023 WAST commissioned a clinical model design of the Trust's EMS service by ORH.⁹ The work recommended that 999 calls should be reviewed and either referred for a fuller remote clinical assessment or returned to the queue to receive an ambulance dispatch. After receiving an increased core allocation to its base budget in 2024-25 due to inflation, the Trust decided to progress this recommendation and recruited 28 clinical navigators to launch the first phase of its Clinical Model Transformation Programme in November 2024. Unverified data for December 2024 showed the rate increasing from under 15% to over 20%.
- 34 When a call is ended through consult and close, a patient may have received a range of advice which can include self-care, contacting their GP within normal working hours, or signposting to other available services, (as set out in **Exhibit 5**). Within the Trust, there has been an increase in the range of available services to directly refer to. These include the mental health '111 press 2' service which directs patients to mental health support, as well as the urgent dental service to book urgent appointments. The urgent dental service is available via 111 for five of the seven health boards (excluding Aneurin Bevan and Cardiff and Vale who have their own services).
- 35 In 2023, the Trust also developed its capability to remotely monitor and manage patients within the community through the Connected Support Cymru service. This

⁸ Data not available beyond April 2024.

⁹ ORH, also known as Operational Research in Health Ltd, is a company which conducts research and analysis of emergency services aimed at optimising resource use and response.

service uses the support of volunteer responders, clinical support desk clinicians and remote monitoring technology to manage patients remotely and keep them at home, where appropriate. This service is currently in its early stages, with plans for it to be scaled up over the next few years as outlined within the Trust's IMTP 2024-27. However, this service currently utilises short-term funding from NHS charities together which is due to conclude in March 2025. The future of this service depends on the level of additional investment available.

- 36 Whilst the rate of patients treated at scene increased during the 12 months between March 2024 and February 2025, the rate has decreased slightly over a longer period. Between March 2019 and February 2020, the rate stood at an average of 2,770 patients treated at scene per month, compared to an average of 2,321 between March 2024 and February 2025.
- 37 The Trust has been expanding its advanced paramedic practitioner service to avoid hospital conveyance and improve patient outcomes. Advanced paramedic practitioners provide enhanced treatments to patients within their homes or communities. Since the introduction of the advanced paramedic practitioner role in 2017, the number of these roles within the Trust has increased to 119 as of February 2025, with recruitment of a further 11 currently underway. The Trust's IMTP sets out plans to further increase this workforce by 40 per year up to 2027, dependent on availability of funding. Case studies, local evaluations and interviews show that the advanced paramedic practitioner role is making a significant impact in treating patients closer to home. However, this is not currently being demonstrated clearly within 'see and treat' data that is available. The Trust is undertaking work to understand the reasons for this.
- 38 In addition to advanced paramedic practitioners, the Trust has developed a Cymru High Acuity Response Unit (CHARU) which provides advanced care to the most critically ill patients, including those experiencing cardiac arrest or major trauma. Data presented to the Trust's Finance and Performance Committee in September 2024 shows the service supporting better outcomes for 'red' calls such as cardiac arrests.
- 39 For urgent needs that are not immediately life-threatening, the Trust is also seeking to develop its own services, including falls responders. The Trust provides two levels of falls response services, with level one focused on lifting patients from the floor. Level two works with health boards to provide greater support to patients following a fall that are experiencing worsening frailty, by undertaking a full medical and social assessment at the point of need.

Referral to other services

- 40 As well as the availability of its own alternative services, the Trust's ability to refer patients to alternative services depends on the availability of those services within the health board regions. We found each health board has a range of services in place to manage and treat urgent and emergency care needs.

- 41 **Exhibit 5** sets out the extent to which 111 has been able to refer patients to other urgent and emergency services.

Exhibit 5: referral to other services (March 2023 - February 2024)

Indicator	All-Wales position	Trend
% of 111 calls referred to GP out of hours	41.5	
% of 111 calls advised to attend Emergency Department / Minor Injuries Unit	10.6	
% of 111 calls referred to urgent dental service	9.7	
% of 111 calls referred to 999	6.7	
% of 111 calls advised to contact their GP (in-hours)	4.6	
% of 111 calls referred to another health professional	2.0	

Source: DHCW Urgent and Emergency Care Dashboard, GP Out of Hours Data, Ambulance Services Indicators

- 42 The data shows that the most common service 111 callers are referred to is the GP out of hours service, with this rate increasing between March 2023 and February 2024. This rate aligns to public messaging which signposts patients with urgent out of hours needs to contact 111 to access GP out of hours services and suggests that public messaging is generally working effectively in this regard. The rate with which 111 call handlers refer patients to contact their own GP in hours (4.6%), indicates that patients could be better informed about which service to access, however it is also likely to reflect how the public are increasingly struggling to gain appropriate access to in-hours GP appointments due to capacity issues within primary care. The low rate of referrals to other health professionals (2%) also suggests that there are limited alternative services in place for 111 call staff to refer patients with specific conditions to access.
- 43 Between February 2022 and February 2024, 5.2% of 999 calls were transferred to the 111 service, on the basis that the calls were deemed non-urgent and therefore could be dealt with through alternative services. However, 27.7% of these calls were transferred back to 999 with an outcome of 'ambulance required' This comparatively high rate suggests that while these cases are not sufficiently urgent to warrant a 999 response, options for alternative services were either not in place or not accessible.
- 44 To facilitate effective referral between the Trust and health boards, there needs to be a sufficient range of appropriate pathways that the Trust staff are aware of and can access. One of the key ambitions of the Clinical Model Transformation Programme is to increase collaboration between the Trust and health boards to

identify potential pathways for patients, and to ensure that Trust clinicians have appropriate access to those pathways, either by streaming patients to health board clinical hubs, or directly to a care pathway via the directory of service.

- 45 The Trust holds a directory of service for each health board area. Directories of service have been set up to hold accurate and up-to-date information on available alternative pathways that patients can be signposted to by remote clinicians and paramedics. However, our fieldwork found that arrangements for maintaining the directories of service need to be strengthened between the Trust and health boards to ensure they are accurate and up to date, including containing the right opening hours for services (**Recommendation 2**).
- 46 Where pathways are established, our fieldwork also found that there are issues with ensuring Trust staff can access them. This can be because:
- referral criteria is unclear or too limited;
 - pathways do not allow for referrals from Trust staff; or
 - the extent of variation in the way in which services operate make them more challenging for Trust staff to access consistently or efficiently.
- 47 Interviews with a range of staff groups suggested that the inconsistencies in the availability of, and access to, alternative services serve to reinforce Emergency Departments as the default destination for ambulance conveyances.
- 48 In line with the ambitions of the Six Goals Programme, some health boards have established Urgent Primary Care Centres (UPCCs). The principle of UPCCs is to provide diagnosis and treatment to patients with urgent but non-life-threatening injuries or illnesses. However, the UPCC models developed in response to the Six Goals Programme vary within and between health boards. The Trust has been piloting booking patients directly into UPCCs from the 111 service, but this is limited to a small number of appointments and for very specific conditions. This stops Trust staff from using UPCCs to their full potential to manage urgent demand in the way they are intended.
- 49 Another key ambition of the Six Goals Programme was for health boards to establish Same Day Emergency Centre(s) (SDECs) to provide same day assessments and treatment without the patient needing to be admitted into hospital overnight. We have found that the SDEC models developed in response to the Six Goals Programme also vary across health boards. This variation results in a lack of clarity for Trust staff as to the referral criteria in place and the pathways they should use to access SDECs.
- 50 In response to this issue, Welsh Government issued an all-Wales policy on direct paramedic referral to same day emergency care in April 2022. The policy clarifies the different expectations of Trust and health board staff to support effective referrals into SDECs. However, despite the policy stating that it is 'essential for the Welsh urgent and emergency care system that direct paramedic referral into SDEC/Ambulatory services is implemented', Trust data shows that, between May

2023 and February 2025, on average only 0.13% of patients conveyed were taken to a health board SDEC each month.

- 51 We heard varying reasons for this low rate of referral during our fieldwork. This included technical issues but more prominently because SDEC units tend to become full within minutes of opening due to broader pressures on Emergency Departments. They then remain full until it becomes too late to accept any new referrals before the units close.

Impact of services to help manage demand

- 52 We found that **recent work to reduce conveyance to Emergency Departments is outweighed by unacceptably long handover delays across Wales**

Ambulance response times

- 53 Data shows that demand on the Trust's services, particularly in relation to red calls, has increased, placing additional strain on its ability to provide a timely service. Red calls across Wales increased by 178% between February 2019 and February 2025, with an average of 5,367 red calls per month between March 2024 and February 2025 (an average of 179 calls per day). This is in part due to the need to increase the number of conditions within the red categorisation to ensure they receive a timelier response. Whilst the number of amber calls has declined slightly since the pandemic, they continue to account for most of the 999 calls, with an average of 24,412 calls per month between March 2024 and February 2025 (an average of 814 calls per day).
- 54 The average percentage of red calls responded to within eight minutes between March 2024 and February 2025 was 48.6% and significantly below the target of 65%. However, during those 12 months, performance has improved with the Trust reaching a greater number of patients within eight minutes. For example, in December 2024 and January 2025 the Trust reached 33% and 22% more patients than its average two-year rate. Following the recent announcement by the Cabinet Secretary for Health and Social Care there will be changes to monitoring performance, with the creation of two separate metrics: one for cardiac and respiratory arrest; and another for other red emergency calls. These changes will take effect from 1 July 2025¹⁰.
- 55 In contrast to red calls, responses to amber calls have become significantly poorer in recent years. On average, the response time to amber calls between March 2024 and February 2025 was 1 hour 50 minutes, rising to 9 hours 58 minutes for the patients who waited the longest (95th percentile). This performance fluctuated during those 12 months, with significant deterioration during December 2024 and

¹⁰ On 11 March 2025 the Cabinet Secretary for Health and Social Care announced changes to the performance framework for ambulance services effective from 1 July 2025.

January 2025 due to winter pressures. Average response times for those months were 3 hours, 1 minute and 2 hours, 29 minutes respectively.

- 56 Call handlers provide patients with their estimated response time during their call. As a result, since 2022 a significant proportion of 999 callers have called back to cancel their place in the queue for an ambulance response ('cancelled calls'). There have also been circumstances where call handlers have been required to inform patients that they were unable to dispatch an ambulance response to them due to operational pressures at that time ('no send/can't send'). Concerningly, there is no method to capture what happens to these patients to find out if they decided to make their own way to the Emergency Department, found alternative services for their needs or simply decided not to receive treatment.
- 57 The Trust routinely captures and reports data on the number of cancelled calls or calls that received a 'no send/can't send' response. In September 2024, this cohort accounted for 9,440 calls or 21% of patients who dialled 999 that month. Further work by the Trust has established that up to 20% of all cancellations come from patients presenting with chest pain or falls, conditions that can result in significant patient harm. The Trust Board has heard directly about the impact this can have on patients, including a patient story during 2023 where a patient suffered a cardiac arrest within the hospital car park after being driven to hospital by a family member due to lack of ambulance availability.
- 58 As part of the Clinical Model Transformation Programme, the Trust took the decision in November 2024 to stop providing a 'no send/can't send' response, relying on the impact of its new changes such as rapid clinical screening to better manage demand. This means that the Trust takes greater responsibility for the patient and patient risk. This appears to be starting to have a positive impact, as data from February 2025 shows that the numbers of cancelled ambulances had reduced to 5,815, accounting for 15% of the total calls for that month.

Conveyance to hospital

- 59 After the ambulance has been dispatched and it is decided that the patient needs hospital assessment and treatment, they will be conveyed. Whilst the conveyance rate to hospital by the ambulance service was substantially impacted during the pandemic, data since 2023 shows a steadily decreasing conveyance rate when compared with pre-pandemic levels, with rates dropping from 68% (19,022 patients) in February 2019 to 63% (11,705 patients) in February 2025.
- 60 Data that shows where patients are conveyed to indicates further opportunities to increase conveyance to destinations other than the Emergency Department. **Exhibit 6** sets out the destination for all conveyances.

Exhibit 6: conveyance destination as a proportion of total conveyance (March 2024 – February 2025)

Indicator	All-Wales position	Trend
% of patients conveyed to major emergency departments	88.7	
% of patients conveyed to minor injuries units	6.4	
% of patients conveyed to major acute medical admissions unit	3.1	
% of patients conveyed to other unit e.g. mental health or maternity unit	1.8	

Source: Ambulance Services Indicators

- 61 The overwhelming majority of conveyance continues to be to Emergency Departments. This is likely to be the most appropriate destination for many calls, which, are by their nature, urgent and/or life-threatening. However, our interviews with ambulance and health board staff suggest that barriers exist which inhibit ambulance crews from conveying patients to settings which may be more appropriate for their needs.
- 62 For example, conveyance rates to minor injuries units are consistently low. Part of the reason for this is that there is significant variation in opening hours and criteria for accepting referrals to the minor injuries units operating within and between health boards. As a result, those we interviewed stated that paramedics will tend to rely on Emergency Department conveyance. This reduces the risk that the patient will not be accepted by the minor injuries unit, which results in poor patient experience and inefficiencies in having to undertake additional transportation to the Emergency Department.
- 63 We also heard that some alternatives to the Emergency Department, such as direct referral to units within specialties can be reluctant to accept referrals from paramedics. This is due to the types of observations and tests paramedics can complete. These services would prefer for patients to be routed through the Emergency Department first.
- 64 However, data on conveyance to hospital following 999 calls from a care home is showing some signs of improvement. This rate decreased from a high of 64.8% in November 2023 to a low of 58.7% in September 2024. This suggests that some of the work the Trust is doing to support care homes, including by supplying lifting equipment or providing enhanced falls response services, is resulting in lower rates of conveyance to hospital.

Ambulance handovers

- 65 Data shows that ambulance handover delays continue to be at unacceptable levels. Only 16% of patients were handed over from ambulance crews to an Emergency Department within 15 minutes of arrival between March 2024 and February 2025, against a national target of 100%. This compares to 56% between March 2018 and February 2019. Under half (43.9%) of the patients conveyed to an Emergency Department were handed over within an hour during February 2025. The average time for patient handover in December 2024 was 2 hours, 12 minutes. In England, the average handover delay for December 2024 was 39 minutes.
- 66 These high levels of handover delay result in extremely high numbers of 'lost hours' where a paramedic crew is unable to respond to other calls within the community, with lost hours routinely over 20,000 a month during 2024. This roughly equates to between one quarter or one third of the available capacity of the ambulance service each month. Comparing lost hours for February 2025 with those in February 2019 shows a 235% increase. The lost hours in February 2025 equate to 1,597 12-hour paramedic shifts.
- 67 Research commissioned by the Association of Ambulance Chief Executives (AACE) states that patients experiencing delays of over one hour are much more likely to experience avoidable harm because of the delay they face. Using the modelling developed as part of that research, the Trust has estimated that 463 patients (3.5% of conveyed patients) came to severe harm because of long handover delays in February 2025.
- 68 Despite the Trust's increasing activity to avoid hospital conveyance by remote treatment, either over the phone or in person, data shows that there remains a significant amount of work to do to improve handover performance. Lack of available ambulances will also lead to higher attendance rates at emergency departments across Wales, as patients make their own way to hospital. Some of these patients may not have needed to go to the emergency department, but opportunities for paramedics to treat patients remotely (See and Treat) earlier in their patient journey are being missed due to handover delays.
- 69 Problems associated with handover delays are widely recognised. In March 2025, the Cabinet Secretary for Health and Social Services announced the establishment of a patient handover improvement delivery group. This group is intended to identify and oversee action aimed at improving ambulance patient handover performance, learning from UK-wide and international best practice. An update on the progress of this group's work is anticipated in July 2025.

Scrutiny and monitoring arrangements

- 70 This section considers whether the Trust is doing enough to monitor the performance of its urgent and emergency care services, and applying lessons learnt to improve services further. We were specifically looking for evidence of:
- arrangements for monitoring the impact of alternative clinical pathways; and
 - effective oversight and scrutiny of the delivery of plans for urgent and emergency care.
- 71 We found that **there is good oversight of performance and plan progress relating to urgent and emergency care demand which is informed by staff and patient feedback but is limited by lack of joined up data**

Monitoring impact

- 72 We found that **monitoring of plans is informed by regular staff and patient feedback, but without joined up data the Trust cannot monitor the effectiveness of referral pathways with certainty.**
- 73 The findings that have led us to this conclusion are summarised in **Exhibit 7**.

Exhibit 7: approach to monitoring the impact of alternative pathways on urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Is the Trust tracking and reporting data to show whether patients are accessing urgent and emergency care services appropriately?	Partially	The Trust routinely tracks relevant data on demand, rates of signposting and referral to alternative services (consult and close) and rates of conveyance to hospital units, including Emergency Departments. However, Trust and health board information systems are not currently linked up to enable the tracking of an entire patient journey i.e. to confirm whether patients followed advice they have received.
Is regular patient feedback is being	Yes	The Trust captures patient feedback through regular CIVICA experience surveys ¹¹ . There are

¹¹ Civica Experience is a software which helps healthcare professionals collect and analyse data to turn patient feedback comments into insights.

Audit question	Yes/ No/ Partially	Findings
sought and used to inform and improve plans?		surveys in place for 999, 111 and the Trust's falls service. These surveys capture patient responses to questions including their overall rating of the experience for the service they received, as well as more specific questions, such as whether patients intend to follow the advice they found on the 111 Wales website. The Trust recognises that response rates to these surveys are low, with 371 responses across each of those listed above between April and September 2024, and it continues to explore options to increase participation. Supporting appendices of the Trust's IMTP summarise patient feedback and concerns relating to services, including 111 and 999 services and links them to specific actions within the plan which aim to address those concerns and improve patient experience.
Is there regular staff feedback on the impact of changes to services and pilots to identify and apply lessons?	Yes	The Trust shows a commitment to hearing from staff, including via monthly WAST Live virtual staff meetings, surveys and bi-annual Chief Executive Officer roadshows held in ambulance stations and offices across Wales. Furthermore, the Trust involves trade union representatives in key working groups and each board committee, as well as through the Welsh Ambulance Service Partnership Team. These mechanisms provide a staff perspective during decision making. In January 2025, the Trust surveyed staff involved in delivering the Clinical Model Transformation Programme and the associated new initiatives. The survey asked staff for their views on the way in which changes have been implemented. The response rate was low at 17% (30 responses) and whilst overall scores were mostly positive, comments included concerns about the pressure caused by the pace and scale of the programme, as well as a need for more regular and meaningful staff engagement. The Trust is currently developing actions to respond to these concerns.

Audit question	Yes/ No/ Partially	Findings
		Staff feedback and related actions to address areas of concern are also included within an appendix of the Trust's IMTP.

Source: Audit Wales

Oversight and scrutiny

74 We found that **there is regular operational and strategic oversight and scrutiny of the performance and the delivery of plans**

75 The findings that have led us to this conclusion are summarised in **Exhibit 8**.

Exhibit 8: approach to oversight and scrutiny of urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Is there effective oversight of urgent and emergency care performance operationally, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?	Yes	The Trust provides operational oversight and scrutiny of its actions to improve demand management through its Clinical Transformation Board, and supporting workstreams, as well as its Integrated Strategic Planning and Development Group. These groups are supported by strong arrangements, including appropriate membership and regular frequency. The Trust continues to oversee and manage performance in line with its Quality and Performance Management Framework 2022-25. Operational performance is scrutinised at detailed levels by various operational, quality and planning subgroups before being collated and submitted for oversight and challenge by the Executive Leadership Team.
Is there effective oversight of urgent	Yes	Performance information on the Trust's urgent and emergency care services is regularly

Audit question	Yes/ No/ Partially	Findings
and emergency care performance at the committee and board level, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?		reported to the Performance and Finance Committee; the Quality, Experience and Patient Safety Committee; and the Board. In 2024, the Trust developed a patient harm mitigation scorecard. This provides a collective set of metrics to indicate the levels of harm that may be occurring as a result of system pressures. However, again this information is limited due to the absence of joined up information between the Trust and its commissioning health boards. As a result, the scorecard only indicates estimated levels of harm based on the AACE model. The Finance and Performance Committee and the Board are also responsible for overseeing the progress of the Trust's Integrated Medium-Term Plan.

Source: Audit Wales

Appendix 1

Audit methods

Exhibit 9 sets out the audit methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 9: audit methods

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Integrated Medium Term Plan and appendices; • Corporate Risk Register and Board Assurance Framework; • Internal Audits; • Winter Plan; and • Clinical Model Transformation Stakeholder briefing document, September 2024.
Interviews	We interviewed the following: • Executive Director of Operations; • Executive Director of Paramedicine; • Executive Director of Strategic Planning and Performance; • Director of Partnerships and Engagement; and • Assistant Director, Commissioning and Performance.
Group discussions	We held group discussions with the following: • Advanced Paramedic Practitioners.
Observations	We observed the following meeting(s): • Finance and Performance Committee; and • Board.
Data analysis	We analysed data relating to urgent and emergency care services, using the following sources: • Ambulance Services Indicators; • Data provided from the Trust, including rates of consult and close and SDEC referrals;

Element of audit approach	Description
	• DHCW Urgent and Emergency Care Dashboard; • StatsWales; and • Data provided by Welsh Government in relation to GP out of hours services.
Website and practice reviews	We reviewed the Trust's website and social media accounts relating to the provision of information to the public on accessing urgent and emergency care services.

All audit work has been delivered in accordance with the International Organisation of Supreme Audit Institutions (INTOSAI) audit standards.

Appendix 2

Audit criteria

Exhibit 10 sets out the audit criteria that we used to deliver this work.

Exhibit 10: audit criteria

Audit questions	Audit criteria
Does the Trust have robust plans in place to manage the demand for urgent and emergency care services?	
Do plans seek to improve the management of demand through changes to service delivery in line with the six goals for Urgent and Emergency care?	• Strategies and/or plans relating to urgent and emergency care: – are based and grounded in rich and up-to-date information, informed by urgent and emergency care demand data (past and future), including peaks in activity at certain times/days and months, demographics, and conditions of patients. – identify and seek to address key risks associated with demand for urgent and emergency care services. – align with the plans of partner Health Boards. – align with the requirements of the Welsh Government Six goals for Urgent and Emergency Care for better managing demand. – include documented information on alternative clinical pathways, including how and when they should be accessed.
Do plans identify the current and required	• Strategies and/or plans detail the:

Audit questions	Audit criteria
levels of resource and staffing to achieve the ambitions?	– resource requirements and identified funding to support any changes to service delivery included within the strategy/plan. – workforce and skills required to meet demand, including for changes in models of delivery such as winter peaks. The plan is clear about the required resources of clinical and non-clinical skills/staff.
Are arrangements in place to encourage and enable people to access the right care, in the right place, at the first time, and are these working?	
Is the Trust effectively signposting urgent and emergency care services to the public, so they know how to access services appropriately?	• The Trust provides clear information on available services and alternatives to emergency departments to the public through various avenues – websites, call handlers, posters/leaflets, advertisements, social media, videos etc. • Strategies and/or plans on public communication align to requirements of goals 2 and 3 of the WG Six goals for Urgent and Emergency Care (Right care, right place, first time) • There is evidence to suggest patients have a good understanding of how to access urgent and emergency care services that are appropriate to their needs
Do staff have good knowledge of, and access to, information regarding the range of other services available to their patients and at what times they are available?	• There is engagement between the Trust and health boards about alternative pathways in place and the future of urgent and emergency care services. Information on these pathways and services are accessible for staff. • Staff can refer directly / divert patients to more appropriate settings for their needs, including Minor Injury Departments, Urgent Primary Care Centres (UPCC) and Same Day Emergency Centres (SDEC).
Is there evidence that changes to service delivery are resulting in	• Referrals into new service models are in line with the ambitions of the six goals for urgent and emergency care policy handbook. • WAST can refer at least 4% of cases to SDEC.

Audit questions	Audit criteria
better demand management?	• Data indicates that there are increasing rates of See and Treat and Hear and Treat. • Calls to 111 are answered quickly and abandonment rates are low. • Emergency ambulance response times, ambulance handover delays and waits within Emergency Departments and Minor Injury Units are improving. • Data indicates that there are fewer amber calls requiring an upgrade to red due to lengthy response times. • Data shows decreasing volumes of patients with low acuity / minor complaints presenting at Emergency Departments. • Data indicates that calls diverted between 999 and 111/NHS Direct Wales are appropriate with low levels of calls diverted back and low numbers of re-contact rates.
Is the Trust doing enough to monitor the performance of its urgent and emergency care services and apply lessons learnt to improve the services further?	
Is the Trust monitoring the effectiveness of alternative clinical pathways, including by seeking feedback from staff and service users?	• The Trust tracks and reports data to show whether patients are accessing urgent and emergency care services appropriately. • The Trust can evidence that it seeks patient feedback regularly and uses it to inform and improve plans. • Regular feedback is sought from various staff on the impact of changes to services and pilots to identify and apply lessons
Is there effective scrutiny and assurance in relation to delivering plans for urgent and emergency care and alternative clinical pathways?	• There is effective oversight of urgent and emergency care performance operationally and at the committee and board level. This includes scrutiny and assurance on the effectiveness of the plans and actions being taken to better meet demand. Oversight and scrutiny are informed by comparative benchmarking and learning from other bodies where appropriate. • There are arrangements in place for monitoring and oversight of economy, efficiency, and effectiveness of project investment from Welsh Government. This includes establishing value for money and what difference the project has made.

Appendix 3

Management response to audit recommendations

Exhibit 11 sets out the Trust's management response to the recommendations made because of this audit.

Exhibit 11: management response

Recommendation	Management response	Completion date	Responsible officer
Accuracy of 111 Wales website R1 To ensure information used to signpost patients to urgent and emergency services are accurate, the Trust should work with partners to review and replace any out-of-date or misleading information on the 111 Wales website, for example, the NHS Direct Wales phone number (Paragraph 28) .	The Trust accepts this recommendation. While WAST is not directly commissioned to manage the 111 Wales website, we fully support the need for accurate content to signpost patients safely. We routinely raise concerns, such as outdated references to NHS Direct Wales and will strengthen this by formally escalating issues through an agreed assurance route with Digital Health and Care Wales. A business case has been drafted to propose a new governance model with dedicated resources for oversight and content management to improve accuracy and ownership. Discussions with Welsh Government are ongoing regarding financial envelopes and commissioner expectations, which are prerequisites to formal submission.	May 2026	Director of Digital Services

Recommendation	Management response	Completion date	Responsible officer
	Website content accuracy will be a standing item at the monthly 111 Wales digital governance group. Over the next 12 months, issues will be actively monitored, and formal escalations logged to demonstrate progress and provide evidence of action taken.		
Directories of Service R2 To ensure the Trust has access to accurate and up-to-date information on health board services it should work with health boards to identify leads for maintaining the directories (Paragraph 46).	The Trust accepts this recommendation. We agree on the need for accurate and up-to-date service information. While WAST does not control the content provided by health boards, we maintain mechanisms to receive and manage this data. The recommendation is therefore best addressed through strengthened collaboration with health boards, who remain responsible for the accuracy of their service information. A business case has been drafted to improve Directory of Services (DoS) governance and support. Discussions with Welsh Government are ongoing regarding financial envelopes and commissioner expectations, which are prerequisites to formal submission. WAST will continue to update any content we own/publish into to the DOS and will escalate outdated information to relevant health boards. This will be monitored over 12 months, with escalations logged as evidence of action.	May 2026	Director of Digital Services

Source: 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.



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Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

AGENDA ITEM No	7
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	2

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit, Risk and Assurance Committee
DATE	24 June 2025
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
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EXECUTIVE SUMMARY

1. The purpose of the report is to provide a detailed update to the Audit, Risk & Assurance Committee (ARAC) on the 2025/26 Risk Management work programme and assurance in respect of the management of the Trust's principal risks.

Risk Management Work Programme 2025/26

2. This year's work programme is underway and a detailed update on progress and plans is drawn out throughout the report. This includes work on the development of a suite of Risk Appetite statements, recruitment of a Risk Manager, continued work to reposition the Trust's highest rated Risks 223 and 224, an electronic risk management solution and the future for strategic risk and the strategic Board Assurance Framework (BAF).
3. While there is an outline plan for this year's work programme, the team will be exploring new ways of working and require the flexibility to adjust timings and outputs; however, regular updates will be provided to ARAC for oversight as the work progresses.
4. A key piece of work is underway to finalise the six Risk Appetite statements (RAs). The next steps are to refine RAs 1-4, already considered by the Board in February 2025, and develop the two remaining RAs 5 and 6 with the Strategic Transformation Board on 11 August 2025 for sign off by the Trust Board.
5. Work is progressing on the strategic Board Assurance Framework (BAF) which will be a focus of 2025, and the knowledge share continues with our consultants, BDO. There is potential for a Board Development Day (BDD) session in February 2026 to pilot of one or two strategic risks, developed in the latter part of this year, and test how these may be used for decision making.

6. Discussions are underway with the Planning and Performance team as the narrative and metrics for what good looks like in the IMTP are developed to include the Trust's high level risks. This will support the ongoing development of the strategic BAF in a more focused and meaningful way.
7. The third round of recruitment for a Risk Manager is underway with external advertising secured on the Enterprise Risk Management website, which is hosted by the Institute of Risk Management. The closing date is 15 June 2025 with a provisional interview date of 11 July 2025.

Repositioning Risks 223 and 224

8. Work has continued to review 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*, in detail and implement a new approach to the way these risks are presented.
9. The new approach separates controls, assurances and gaps into internal and external themes and categories. A working draft of Risk 223 is included with this paper for discussion purposes and to highlight the direction of travel. There is still work to be done on this document.

Board Assurance Framework

10. As highlighted during the programme of effectiveness reviews, Members acknowledged that reporting of current, principal risks contained in the Board Assurance Framework (BAF) are effectively reported through board and committees.
11. A summary of the principal risks is included (Annex 1) with a detailed description contained within the BAF. All updates are highlighted in blue.
12. The BAF has been included in the new reading room facility in Ibabs, which is a digital space that hosts documents. Access to the reading room is through the documents/shared folder in Ibabs' main menu. The BAF remains available on the website.
13. This document has been included in the reading room given its significant size and given it has been reviewed by each of the committees during this quarter. Any changes to principal risks have been drawn out within this report.
14. The more detailed description contained within the BAF provides 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).

15. Members can take assurance that each of the principal risks have been reviewed in line with the agreed schedule detailed at Annex 3 and that the Executive Leadership Team (ELT) approved the principal risk activity on 21 May 2025 having considered the review of each risk undertaken throughout April and May 2025 by Risk Owners and the Assistant Director Leadership Team (ADLT).
16. Additionally, the ADLT received a dashboard in April 2025 showing the number of mitigating actions against each principal risk, their completion dates and the anticipated impact on the target scores. This work aims to assist Directors and their teams to discuss risk mitigation with a closer focus on the actions required to achieve target scores. This is to test whether the risks are well controlled despite not increasing in score; the teams need to consider whether we are content with the level of risk being carried.
17. A further dashboard describing risk score trends and movement over time has been produced which supports the deep dive programme being undertaken on the principal risks at ADLT over the next 6 months. The outcome of this work will be included in the committee risk reports where relevant to their remit.
18. This report and the risk management work programme outline the significant work undertaken, to keep under review, the Trust's principal risks, which are before committee today for scrutiny.
19. There have been no material changes to the principal risks during this period; however, each of the Committee AAAs were presented to the Board on 29 May 2025 and described the discussions against risks within their remit. Additionally, 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.

High Level Summary of the 2025/26 Work Programme

20. The outline programme of work includes:
 - June 2025: Continued work on repositioning Risks 223 and 224
 - July 2025: Anticipated appointment of a Risk Manager to the team
 - July 2025: Electronic Risk Management system demos
 - August 2025: Finalise Risk Appetite Statements (RAs)
 - September 2025: Sign off RAs by ARAC and the Trust Board
 - February 2026: Board Development Session – pilot of one or two strategic risks
 - March 2026: Draft front cover of a Strategic BAF presented to committee

RECOMMENDATION:

21. Members are asked to receive assurance on progress of the 2025/26 Risk Management work programme and timelines, and:
 - a. Note the development of risk appetite statements.

- b. Note the ongoing repositioning of Risks 223 and 224.
- c. Note the next steps in relation to a digital risk management solution.
- d. Receive assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant committees.
- e. 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 (28 April 2025)
- Executive Leadership Team (21 May 2025)
- Trust Board (29 May 2025)
- Audit, Risk and Assurance Committee (24 June 2025)
- Finance & Performance Committee (22 July 2025)
- Quality, Safety & Patient Experience (05 August 2025)
- People & Culture Committee (12 August 2025)

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 – Risk 223 DRAFT

Annex 5 – Principal risk trending data

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 report has several elements, firstly to provide an update on the risk management work programme for 2025/26 and assurance in respect of the management of the Trust's principal risks. Additionally, it provides short updates on the procurement of an electronic risk management system and finally an update on recruitment.

BACKGROUND

2. The Risk Management programme is reported and monitored through the Corporate Governance Directorate's Directorate Plan and to the Audit, Risk & Assurance Committee (ARAC) for oversight.
3. The direction of travel and next steps for this year's work programme was presented in detail to and supported by the Executive Leadership Team (ELT) and Committee in September 2024 and reinforced by the recommendations made by our external consultants, BDO in their report.
4. 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.
5. 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 ELT in relation to risk escalation, changes in ratings, and any new risks for inclusion on the Corporate Risk Register (CRR).
6. 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

Risk Appetite Statements

7. Work continues with the development of a suite of Risk Appetite statements (RAs). 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.

8. The team will work with the Strategic Transformation Board in August 2025 to finalise all six RAs. These will be shared with the Trust Board for comment and presented to the September 2025 meeting of ARAC to agree and set the appetite against each of the Trust's six strategic objectives.
9. RAs 1-4, having already been considered by the Board, will be refined and finalised. The remaining two statements, 5 and 6 will be developed. over the next quarter.
10. Once complete, this work will address the one outstanding Internal Audit recommendation, action 596, which was due to be completed in March 2025; however, it is likely that this work will now be finalised in September 2025 rather than May 2025 as previously indicated.
11. A guideline will be developed on the use of Risk Appetite as an agreed action in the 2024/25 Internal Audit review to outline how the risk appetite can effectively be employed as a key strategic tool to enhance decision making by the Board.
12. Time will be set aside with the Board to approve the risk appetite statements and set the risk appetite against each of the strategic objectives. Consideration will be given to the risk appetite thresholds and tolerances and test how we may these for decision making.
13. Following this, the team will develop and pilot one or two strategic risks against the strategic objectives, begin to design risk appetite monitoring metrics and set up a reporting mechanism to monitor compliance against the risk appetite limits.
14. Work is progressing on the strategic BAF which will be a focus of 2025. The team is keen to continue to work with external consultants to share knowledge and expertise on this and a proposal is being worked through in terms of timelines and cost.
15. A draft front cover of the BAF will be developed for discussion at ARAC; the goal being to provide assurance to the Board that the key risks to the strategic objectives are being managed effectively.
16. Additionally, this will provide the Board with a clear and comprehensive view of both the strategy and what good looks like in 2028, and the strategic risks which will support effective and strategic decision making.
17. Discussions are underway as the metrics are developed to measure the 'what good looks like' in the IMTP; it is important to consider what the risks are to achieving these as the two go hand in hand. This work will support the development of the strategic BAF in a more focused and meaningful way;

however, the team will be exploring new ways of working and require the flexibility to adjust timings and reporting to ARAC as the work progresses.

Principal Risks

18. The principal risks have been reviewed in line with the agreed schedule detailed at Annex 3 and the Executive Leadership Team (ELT) approved the principal risk activity on 21 May 2025 having considered the review of each risk undertaken throughout April and May 2025 by Risk Owners and the Assistant Director Leadership Team (ADLT).
19. Each of the risks have been reviewed with a 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.
20. An exercise has been undertaken with the ADLT to consider the number of mitigating actions against each principal risk, their completion dates and the anticipated impact on the target scores. This work aims to assist Directors and their teams to discuss risk mitigation with a closer focus on the actions required to achieve target scores. Additionally, it helps to test whether the risks are well controlled despite not increasing in score and give consideration as to whether we are content with the level of risk being carried.
21. A further dashboard describing risk score trends and movement over time has been produced and is attached at Annex 5.
22. 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.
23. 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.
24. 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.

25. The number of lost hours due to handover delays remained significant reported at 21,854 in March 2025 and 21,193 in April 2025.
26. 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 paper which is presented at each Board meeting. Further mitigations and transformative actions are described in the Integrated Medium Term Plan (IMTP) and are presented to committees and Trust Board in a variety of reports e.g. IMTP Assurance Report and described in the Monthly Integrated Quality & Performance Report to address these risks.
27. There are a range of efficiencies described in the report that the Trust has undertaken in mitigation of these two risks. A key one being that a Handover Improvement Group has been established by the NHS Executive. The Terms of Reference and scope of work has yet to be defined; however, it is being led by the Director of Operations at the NHS Executive.
28. Most of the Trust's actions in the avoidable harm dashboard 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.
29. It is important to note that while some of the target dates of the mitigating actions are showing in the past, there has been close scrutiny of these two risks in dedicated workshops; the outcome of which is presented to Members today for discussion.
30. The Quality, Patient Experience and Safety Committee (QuEST) reviewed both risks at its meeting in May 2025 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.
31. **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, the Health and Wellbeing Plan 2025-2029 and People and Culture Plan 2023-2026 provide strategic direction for relevant initiatives to support the mitigation of this risk. The Assistant Directors Leadership Team will undertake a deep dive of the risk on 09 June 2025 as part of a revised approach to risk.

32. **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. The risk was discussed at the last People & Culture Committee on 15 May 2025 and the tension in the reputational risk was noted that while the Trust has positive relationships with stakeholders, the patient experience remains poor due to harm in the community. A deep dive will be conducted on the risk over the summer to consider splitting it into a stakeholder risk and a patient experience reputational risk. This approach aims to address the different aspects of reputation and ensure the risk is accurately profiled.
33. **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 20 (4x5) due to the escalated world conflicts and recent increase in targeted cyber-attacks against NHS organisations. A review was undertaken by the Closed meeting of the Finance & Performance Committee on 20 May 2025 with several issues also raised in the cyber management report. The discussion was held in closed session due to the sensitive and security based nature of the report and is included in the closed session of ARAC today.
34. **Risk 641** *The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident* remains static at a score of 20 (4x5). This risk is taken in open session of the Board in full transparency. However, members will note that the actions to address individual recommendations are not included in detail in the BAF extract. This is for reasons of sensitivity and security.
35. **Risk 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* remains static at a score of 16 (4x4). This risk was discussed in detail at the FPC on 20 May 2025.
36. **Risk 558** *Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures,* **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* and **Risk 623** *Failure to comply with Data Protection Legislation* all remain unchanged this period and static at a score of 15 (3x5). The Welsh Ambulance Services Partnership Forum (WASPT) will undertake a deep dive on **Risk 558** at its July 2025 meeting.
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* and **Risk 163** *Maintaining Effective & Strong Trade Union Partnerships* remain unchanged at a score of 12 (3x4). The WASPT undertook a detailed review of this risk at its meeting on 30 May 2025 and it was agreed that the risk was appropriately scored and highlighted the evolving nature of partnership working. Since March 2023, risk scoring trends (Annex 5) have reflected challenges - some

stemming from industrial action. However, current partnership working is on a much stronger footing, with clear articulation and demonstration of how social partnership should operate at the Trust.

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.

Repositioning of Risks 223 and 224

39. Work has continued throughout March and April 2025 to undertake detailed reviews of the Trust's highest scoring risks with members of the Risk Owner's senior teams to contribute to the design and development of a different approach to managing and monitoring those areas that are within the Trust's control and those that are not.
40. The internal and external controls, assurances and gaps have been separated into those that the Trust manages and those that it monitors. The next steps will include testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death.
41. Each of the assurances against the controls have been described over three lines of assurance. A future piece of work will be undertaken to score the effectiveness of these controls and assurances.
42. The way the data is being presented in themes and categories supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level in the same way that this is done for other risk such as the Manchester Arena Inquiry and Cyber Security Risk.
43. A working draft of Risk 223 is included with this paper for discussion purposes and to highlight the direction of travel. There is still work to be done on this document.

Risk Manager Recruitment

44. The third round of recruitment for a Risk Manager is underway with additional advertising secured on the Enterprise Risk Management website utilised by the Institute of Risk Management as well as through the usual channels and social media networks. The closing date is 15 June 2025 with a provisional interview date of 11 July 2025.

Electronic Risk Management System

45. In relation to the electronic risk management solution; the Trust will remain on the current Datix Risk Web module at no additional cost until November 2027. The Trust's team is considering several digital solutions with the support and expertise of digital colleagues including options to buy then build our own electronic platform within two years.

RECOMMENDED

22. Members are asked to receive assurance on progress of the 2025/26 Risk Management work programme and timelines, and
- a. Note the development of risk appetite statements.
 - b. Note the ongoing repositioning of Risks 223 and 224.
 - c. Note the next steps in relation to a digital risk management solution.
 - d. Receive assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant committees.
 - e. Note the ratings and mitigating actions for each principal risk.

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		
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	20 (4x5) 
641 FPC	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	IF the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared THEN there is a RISK that the Trust's Incident Response will be suboptimal RESULTING IN avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability	Executive Director of Operations	20 (4x4) 
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	Executive Director of Finance & Corporate Resources	16 (4x4) 

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		the action plan and within the Welsh Government timelines RESULTING IN negative environmental and social impacts causing and reputational damage		
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) ➔
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) ➔
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	Director of Digital Services	15 (3x5) ➔

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		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.		
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.	IF WAST fails to persuade 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 and staff and key outcomes within the IMTP not being delivered	Executive Director of Strategy Planning & Performance	12 (3x4) ➔
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	IF the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained THEN there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised RESULTING IN a negative impact on colleague experience and/or services to patients.	Director of People & Culture	12 (3x4) ➔
139 FPC	Failure to Deliver our Statutory Financial	IF the Trust does: not achieve financial breakeven and/or	Executive Director of Finance &	8 (2x4) ➔

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
	Duties in accordance with legislation.	• does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) THEN there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Corporate Resources	

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.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public 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

Risk ID 223	The Trust’s inability to reach patients in the community causing patient harm and death		Date of Review:				TREND	OVERALL 25 (5x5)	
			Date of Next Review:	MONTHLY			➡		
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		External (LxC)			Internal (LxC)		
			Inherent						
			Current						
			Target						

Strategic objective 1: Providing the right care or advice, in the right place, every time

Work has continued to contribute to the design and development of a different approach to the Trust’s highest scoring risks in a way that describes the internal and external controls, assurances and gaps which have been separated into those that the Trust manages and those that it monitors.

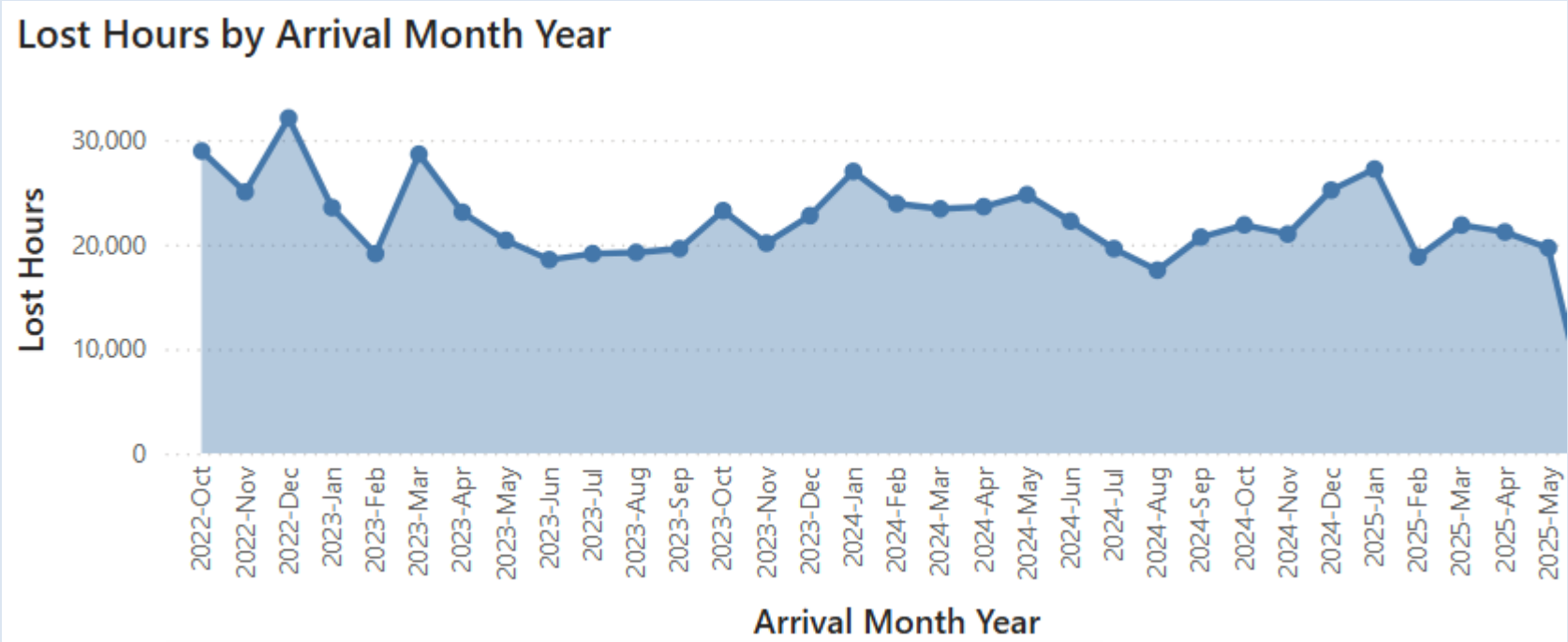
The next steps will include testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death.

Each of the assurances against the controls have been described over three lines of assurance. A future piece of work will be undertaken to score the effectiveness of these controls and assurances.

The way the data is being presented in themes and categories supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level. This working draft is for discussion purposes and to highlight the direction of travel. There is still work to be done on this document.

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

Risk Commentary



DRAFT Risk Appetite Level – Open

We are open to taking risks regarding changes to processes impacting the right care or advice. We understand that innovation and improvement may involve some risk, and we are prepared to embrace these opportunities to enhance our service delivery.

CONTROLS		ASSURANCES	
MONITOR - External		External Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.	
1. External Handover Improvement Group (NHS Exec)		1. Established handover improvement group led by the Director of Operations, NHS Exec to address persistent delays in ambulance handovers at Emergency Departments. The groups' purpose is to coordinate improvement plans across Health Boards, monitor compliance with national guidance and facilitate audits and performance tracking through NHS Exec oversight.	
2. Welsh Health Circular		2. Setting national standards for 15-minute patient handover timeframe, clinical practice, quality governance and operational safety mandating actions like early warning score implementation and infection control whilst also embedding legal compliance through	

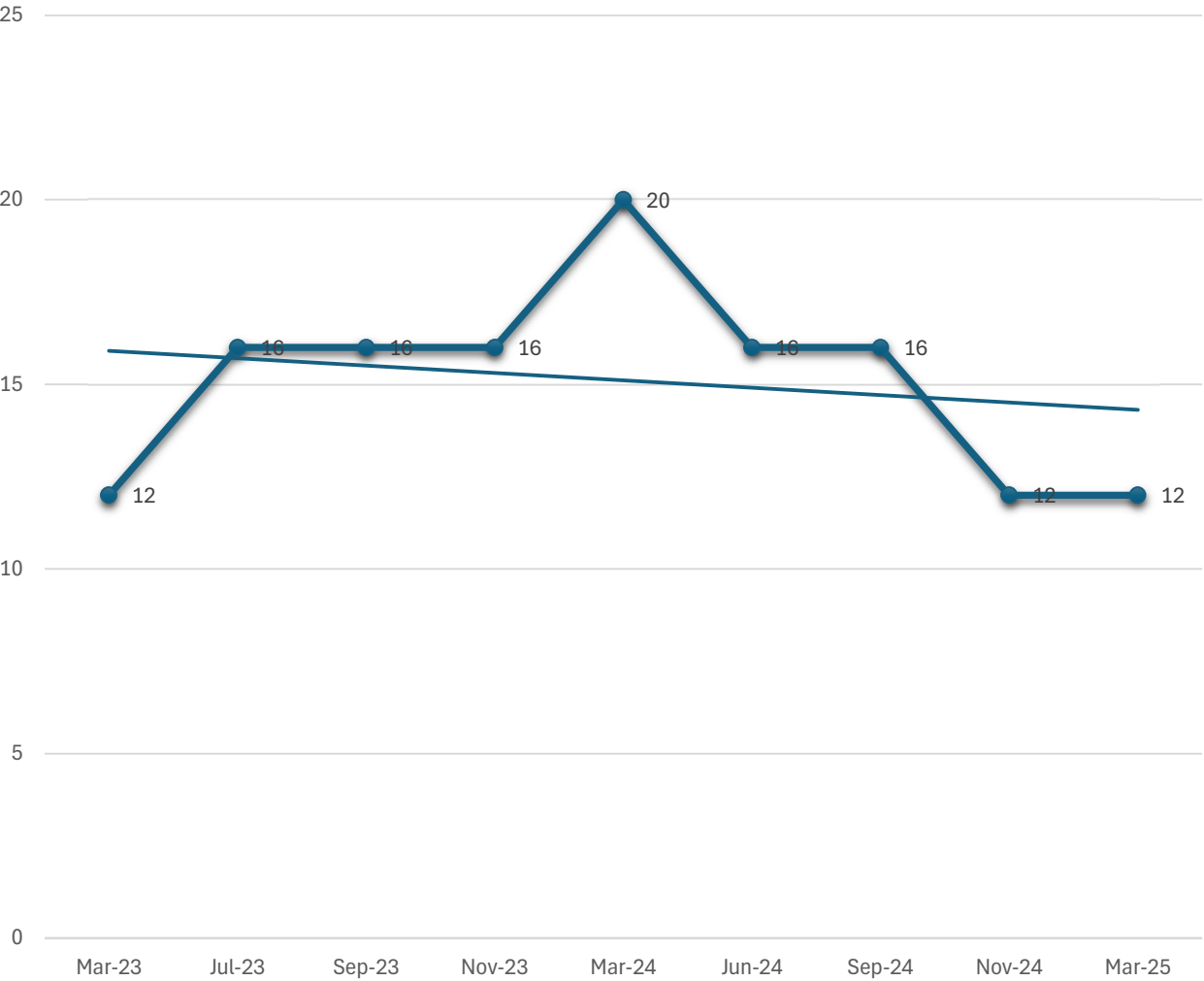
Risk ID 223	The Trust’s inability to reach patients in the community causing patient harm and death		Date of Review:			TREND	OVERALL 25 (5x5)	
			Date of Next Review:		MONTHLY	➡		
			frameworks e.g Duty of Quality. Outcomes are primarily overseen by the Welsh Government through a combination of national audit programmes and governance frameworks. The External Handover Improvement Group has been established consider the elements of the Welsh Health Circular.					
3. Local Delivery Units – Hywell Dda and BCU			3. A model to replicate oversight and scrutiny across Health Boards, like the Trust’s Operational Delivery Unit (ODU). Activity will be based on the System Escalation Framework actions complemented by Local Action Plans – Date of implementation of LDUs to be confirmed					
4. Ministerial Advisory Group (MAG)			4. Providing independent oversight of NHS Wales performance and recommending standardise clinical pathways to reduce delays and improve outcomes. MAG promotes better use of data to monitor patient safety, while its recommendations are embedded into national risk frameworks and Board Assurance processes to ensure system-wide impact.					
5. Mitigating Avoidable Harm Actions			5. Actions were developed in direct response to persisting and escalating system pressures. The avoidable harm paper outlines a strategic framework to reduce patient risk with key measures including the clinical safety plan, Immediate release protocol and governance via the Serious Clinical Incident Forum (SCIF). Outcomes are monitored through risk scores, DATIX reporting, clinical audits and patient harm indicators. Actions were developed in direct response to persisting and escalating system pressures.					
MITIGATE - Internal How do we know the controls are effective. How will these impact the target risk score?		Internal over the three lines of assurance. How do we know the assurances are effective Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk						
Control 1 – Policies/SOPs Regional Escalation Protocol, Immediate Release Protocol v.1.3 (Released August 2024), Resource Escalation Action Plan (REAP – v5.1 released January 2025), Clinical Safety Plan (CSP – released December 2024).		First Line of Assurance Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly Performance, Demand and Capacity meetings to review REAP levels.		Second Line of Assurance ODU dashboards, Performance Demand and Capacity performance metrics data and DATIX and compliance reporting to the COO’s.		Third Line of Assurance Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)		
Control 2 – Performance/Tactics ETA Scripting, CCC Emergency Rule, Red call performance, Transfer of Care, ARA (Swansea and YGC), EMS Demand and Capacity Review.		First Line of Assurance Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly Performance, Demand and Capacity meetings to review REAP levels. Local Business Meetings performance discussions.		Second Line of Assurance ETA dashboard, UHP reporting in local and business meetings. ODU dashboards, Performance Demand and Capacity performance metrics data, MIQPR (Monthly Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly).		Third Line of Assurance Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)		
Control 3 – Operational Activities National Risk Huddles, Performance, Demand and Capacity meetings, WAST Serious Clinical Incident Forum (SCIF), Operational Handover Group		First Line of Assurance Daily Risk Huddles, Weekly Performance Demand and Capacity Meetings, Local business meetings.		Second Line of Assurance Patient safety highlight reports. ODU Dashboards, Performance, Demand and Capacity performance metrics, MIQPR (Monthly Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly).		Third Line of Assurance Ministerial Advisory Group, NHS Exec Handover Group, Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)		
Control 4 – Resources 24/7 Operational Delivery Unit, Strategic, Tactical and Operational 24/7 system to manage escalation plans, APP (Advanced Paramedic Practitioner) deployment model, APP Navigation, CFR recruitment and deployment and CHARU implementation.		First Line of Assurance CSP review and escalation, On Call team start and end of shift, Performance, Demand and Capacity Meetings, Senior Leadership Team meetings.		Second Line of Assurance Shift reports, CSP review, On Call rota review, APP Dashboard, Volunteer performance highlight reporting.		Third Line of Assurance Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)		
Control 5 – Clinical Model Transformation (CMT) Consult and Close (including Mental Health Practitioners), Clinical review of code sets, Remote Clinical Support, Rapid Clinical Screening, expansion of See and Treat resources.		First Line of Assurance CPAS, DCR and CQGG Meetings, Clinical Model Transformation Project Board. Senior Leadership Team Meetings. Performance, Demand and Capacity Meetings.		Second Line of Assurance Performance, Demand and Capacity metric reporting, CPAS/DCR reporting, Volunteer highlight reporting, clinical model transformation highlight report.		Third Line of Assurance Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)		

Risk ID 223	The Trust’s inability to reach patients in the community causing patient harm and death		Date of Review:			TREND	OVERALL 25 (5x5)
			Date of Next Review:		MONTHLY	➡	
GAPS IN CONTROLS			GAPS IN ASSURANCE				
External			External				
1. Inconsistent compliance with 15-minute handover standard by Health Boards which is inconsistent with the National standard set out by the Welsh Health Circular. Although national guidance exists, adherence is variable across sites and Health Boards, limiting WAST’s ability to fully mitigate risk independently. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.			1. While Health Boards have developed handover improvement plans, there is currently no routine, structured mechanism for independent review or validation of their implementation, progress, or effectiveness. External Scrutiny is primarily limited to periodic updates through forums such as IQPD or JCC which may not provide consistent assurance of impact. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.				
2. Operational pressures within Emergency Departments and inpatient areas continue to affect the ability of Health Boards to consistently adhere to the 15-minute handover expectation, despite the presence of national guidance. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.			2. There is limited independent scrutiny or assurance regarding how capacity pressures within Emergency Departments and inpatient settings are being addressed by Health Boards. These constraints directly affect handover performance but fall outside of WASTs operational control or influence. Limiting the Trust’s ability to mitigate the risk independently. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.				
3. Local Delivery Units limited to 2 Health Board Areas (Hywel Dda and BCU)			3. Inconsistency with the Local Delivery Units being implemented in only two Health Boards however recognising that the LDUs within Hywel Dda and BCU are in their infancy with potential rollout Pan Wales dependant on the success of the measurable outcomes.				
5. Inconsistent pathways across Health Boards			5.				
Internal			Internal				
1. Clinical Model Transformation (CMT) not fully implemented			1. Due to the implementation not being fully established there may be gaps in assurance meaning limited evidence currently or certainty that the controls are working as intended, however, as the model progresses the measurable outcomes will be reviewed and any concerns/issues addressed and monitored through actions. Current methods of monitoring the CMT includes CMT Project Board and an approved governance, reporting structure through T&F Groups.				
2.			2.				
3.			3.				
Actions to reduce risk score or address gaps in controls and assurances		Action Owner (Internal only)	Completion / Milestone date	Progress Update			
1. 6 weeks test of change Morriston		Sonia Thompson, Assistant Director of Operations					
2. Royal Glamorgan working to 45 minute handover		Sonia Thompson, Assistant Director of Operations					
3. Clinical Model transformation (CMT) - 12 month pilot programme conducted to understand the full implications of the changes, identify issues and provide valuable insights into the effectiveness of the Clinical service model.		Pete Brown, Assistant Director of Operations, Integrated Care					
4. Cross reference the IMTP 2025-27 plan/deliverables with Corporate Risk 223		Judith Bryce, Assistant Director of Operations, National Ops and Support					
5. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?		Chief Executive Officer		May 25 – Awaiting report from Audit Wales which will come through Audit Committee.			

Assurance Committee Directorate

Sum of Current risk score

163 - Maintaining Effective & Strong Trade Union Partnerships



Risk ID

Risk Title

163 - Maintaining Effective & Strong Trade Union Partnerships

Linear (163 - Maintaining Effective & Strong Trade Union Partnerships)

Period

Risk ID	Risk Title	Directorate	Assurance Committee	Paper	Period	Compliance	Current risk score	Target risk score	Target risk score met?	Comments
223	Trust's inability to reach patients in the community causing patient harm and death	Operations	QuEST	ARAC	Jun-24	Yes	25	10	No	
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	Quality & Nursing	QuEST	ARAC	Jun-24	Yes	25	6	No	
160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	People & Culture	PCC	ARAC	Jun-24	Yes	20	12	No	
201	Damage to Trust reputation following a loss of stakeholder confidence	Partnership and Engagement	PCC	ARAC	Jun-24	Yes	20	15	No	
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	Operations	FPC	ARAC	Jun-24	Yes	20	10	No	
163	Maintaining Effective & Strong Trade Union Partnerships	People & Culture	PCC	ARAC	Jun-24	Yes	16	12	No	
542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan	Finance and Corporate Resources	FPC	ARAC	Jun-24	Yes	16	8	No	
260	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Digital Services	FPC	ARAC	Jun-24	Yes	15	10	No	
558	Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures	People & Culture	PCC	ARAC	Jun-24	Yes	15	10	No	
623	Failure to comply with Data Protection Legislation	Digital Services	FPC	ARAC	Jun-24	Yes	15	10	No	
100	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Strategy, Planning & Performance	FPC	ARAC	Jun-24	Yes	12	8	No	
424	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	Strategy, Planning & Performance	FPC	ARAC	Jun-24	Yes	12	4	No	
139	Failure to Deliver our Statutory Financial Duties in accordance with legislation	Finance and Corporate Resources	FPC	ARAC	Jun-24	Yes	8	8	Yes	
223	Trust's inability to reach patients in the community causing patient harm and death	Operations	QuEST	ARAC	Sep-24	Yes	25	10	No	
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	Quality & Nursing	QuEST	ARAC	Sep-24	Yes	25	6	No	
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424	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	Strategy, Planning & Performance	FPC	ARAC	Sep-24	Yes	8	4	Yes	De-escalated to Directorate Level

139	Failure to Deliver our Statutory Financial Duties in accordance with legislation	Finance and Corporate Resources	FPC	ARAC	Sep-24	Yes	8	8	Yes	
223	Trust's inability to reach patients in the community causing patient harm and death	Operations	QuEST	ARAC	Nov-24	Yes	25	10	No	
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	Quality & Nursing	QuEST	ARAC	Nov-24	Yes	25	6	No	
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641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Operations	FPC	ARAC	Mar-25	Yes	20	6	No	
542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan	Finance and Corporate Resources	FPC	ARAC	Mar-25	Yes	16	8	No	
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283	Failure to implement the EMS Operational Transformation Programme	Strategy, Planning & Performance	FPC	ARAC	Sep-23	Yes	12	8	No	
223	Trust's inability to reach patients in the community causing patient harm and death	Operations	QuEST	ARAC	Jul-23	Yes	25	10	No	
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283	Failure to implement the EMS Operational Transformation Programme	Strategy, Planning & Performance	FPC	ARAC	Jul-23	Yes	12	8	No	
245	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	Operations	FPC	ARAC	Jul-23	Yes	8	8		Closed
557	Potential impact on services as a result of Industrial Action	People & Culture	PCC	ARAC	Jul-23	Yes	16	8		Closed
223	Trust's inability to reach patients in the community causing patient harm and death	Operations	QuEST	ARAC	Mar-23	Yes	25	10	No	
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557	Potential impact on services as a result of Industrial Action	People & Culture	PCC	ARAC	Mar-23	Yes	16	8		
244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	Operations	FPC	ARAC	Mar-23	Yes	12	12		Closed



GIG
CYMRU
NHS
WALES

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Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

AGENDA ITEM No	8
OPEN or CLOSED	OPEN
No of ANNEXES	0

AUDIT TRACKER 2.0 – APRIL 2025 (2024/25 Q4)

MEETING	Audit, Risk and Assurance Committee
DATE	24 June 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Lisa Trounce, Head of Compliance and Assurance
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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. **Quarter 4 Progress:** There continues to be good engagement with Directorates on the Tracker 2.0. Quarter 4 updates resulted in 58 of a total 114 (51%) open internal audit actions being closed in quarter – this represents a closure rate of 51%, a significant improvement on the 27% reported in Quarter 3.
3. **Closure Rate - Forward Trajectory:** Of the 56 internal audit actions that remain open at the end of Quarter 4, 89% (50 actions) are scheduled for closure within Quarters 1 and 2 of 2025/26 (by September 2025), indicating a continued momentum.
4. **Deadline Management:** There has been a downward trend in the number of actions requiring revised deadlines, which is positive – 22% in Quarter 4, compared with 28% in Quarter 3 and 29% in Quarter 2. This suggests that more realistic timelines are now being applied from the outset.
5. **Reduction of Extensions:** Only three actions remain on a third revised deadline – all relating to the Electronic Patient Clinical Record (ePCR) audit. In light of the improving trend, the Executive Leadership Team (ELT) has removed the option of a third revised deadline for all future audit actions.



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6. **ePCR Audit Update:** Four actions remain open from the 2023/24 ePCR: Clinical Compliance audit. Responsibility for these has now transferred to the Digital Directorate. A review meeting is scheduled for June 2025 to agree next steps.
7. **ARAC Oversight:** Of two internal audit actions under the purview of ARAC in Quarter 4, one has closed, with the remaining action (Risk Management – risk appetite statement) progressing towards a revised deadline and completion by the end of Quarter 2 (September 2025), following recent Board level engagement.
8. **External Audit Progress:** Of the 13 open external audit actions in Quarter 4, 11 (85%) were closed in quarter, a substantial improvement on previous quarters (29% in Quarter 3 and 28% in Quarter 2). The two remaining actions are still within their original deadlines.
9. **Audit Tracker Development:** Work is ongoing to develop **Tracker 3.0**, hosted on SharePoint, with testing planned for Q1 2025/26, followed by training and implementation in Q2. This version will support enhanced reporting, including **Power BI dashboards** tailored for different audiences.

RECOMMENDATION

10. The Committee is asked to:

- (a) **Note** the progress made in closing audit actions in Quarter 4;
- (b) **Note** the ELT's decision to remove the option of a third revised deadline;
- (c) **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.

KEY ISSUES/IMPLICATIONS

As set out above.

REPORT APPROVAL ROUTE

2024/25 Q4 Audit Tracker updates presented to the Assistant Directors Leadership Team on the 14 April 2025.



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REPORT APPENDICIES

Annex 1 – Audit Tracker 2.0 24-25 Q4 – ARAC Actions Only – ARAC 240625 (Open) ~ in reading room

Annex 2 – Audit Tracker 2.0 24-25 Q4 – Copy of Full Tracker - ARAC 240625 (Open) ~ in reading room

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 an update on the current position regarding management actions for audits within the purview of the Audit, Risk and Assurance Committee (ARAC), alongside a broader progress overview for the quarter, for oversight. Copies of the Audit Tracker are available at:

Annex 1 – Filtered to the actions assigned to this Committee

Annex 2 – Full Audit Tracker (with actions shared in private session removed)

BACKGROUND

2. In September 2023, the Audit Committee approved the Audit Process and Reporting Handbook which was subsequently revised to incorporate content from Audit Wales.
3. The Handbook includes roles and responsibilities of key stakeholders including:
 - **Directorate Points of Contact:** Points contact are responsible for progressing audit actions for their respective directorate with the Director and Assistant Directors/Deputies, ensuring that audit actions are included on the monthly directorate meetings, recording updates on the tracker, and escalating concerns where appropriate.
 - **Assistant Directors Leadership Team (ADLT):** The ADLT functions as the forum for approving the closure of audit actions, undertaking a 'check and challenge' role.
 - **Board Committees:** Committees are responsible for receiving relevant audit reports and monitoring progress of associated management actions to address audit recommendations.
 - **Audit, Risk and Assurance Committee (ARAC):** The ARAC scrutinises the progress of audits recommendations overall and escalates to the Board any issues or concerns.
4. Board committees (Quality, Patient Experience and Safety Committee; Finance and Performance Committee; and the People and Culture Committee) have each recently reviewed updates against audit actions under their purview.
5. These reviews are noted in the Committees' Assurance, Advice and Alert (AAA) reports to Board. No issues have been escalated to the Board to date.

ASSESSMENT

Internal Audit: - Full Tracker Review (**Annex 2**)

6. Engagement with directorates on Tracker 2.0 updates for Quarter 4 has remained strong. As a result, of the total of 114 open internal audit actions on the Tracker, 58 have been closed in quarter, representing 51% - a marked improvement from 27% reported in Quarter 3.
7. The table below provides a breakdown of the number of audit action closed in quarter, and whether they achieved their original agreed deadline or were closed after one or more revised date.

Year	No. Actions Closed in Quarter (Q4)	Date Completed			
		Original Deadline	1 st Revised Date	2 nd Revised Date	3 rd Revised Date
2022/23	9	0	2	2	5
2023/24	22	4	10	7	1
2024/25	27	17	10	0	0
Totals	58	21	22	9	6
% of Total Closed in Quarter		36%	38%	16%	10%

8. As shown in the table below, the majority of the remaining open actions (i.e. 50 of the total 56, which equates to 89%) are planned for closure during Quarters 1 and 2 (between April and September 2025).

Year	Total No. of Remaining Open Actions (Q4)	Due for Closure During FY 2025/26 (by Quarter)			
		Q1	Q2	Q3	Q4
2022/23	3	2	1	0	0
2023/24	15	5	9	1	0
2024/25	38	21	12	4	1
Totals	56	28	22	5	1
% of Total Open Actions		50%	39%	9%	2%

9. Of the 114 open internal audit actions updated during Quarter 4, 25 of these have been given proposed revised dates in quarter; which is 22% of the total (compared to 28% in Quarter 3, and 29% in Quarter 2) showing a gradual downwards trend. This indicates greater improved accuracy in setting realistic deadlines within initial management responses.

10. There are two open internal audit actions (681 and 684) that have been assigned a third and final revised date. Both relate to the 2023/24 Electronic Patient Clinical Records: Clinical Compliance internal audit – further information on these is provided under points 14-18.
11. There are three open audit actions on their third revised date, all linked to the ePCR internal audit. This represents 3% of the total number of open actions updated during Quarter 4, compared to 6% in Quarter 3, and 9.5% in Quarter 2, this demonstrates a continued improvement.
12. Earlier this year, the Executive Leadership Team considered the Audit Tracker and, in view of the improved position, agreed to remove the option of a third revised date. It was further agreed to consider removal of the second revised dates towards the latter half of 2026/27.
13. In November 2024, responsible directors appeared at this committee to discuss audit actions that were on their third revised date at the end of Quarter 3 and were due for closure during Quarter 4. Updates on each of these actions is shown below – all but one were successfully closed as planned.

Action Ref:	Audit Title	Executive Lead	3 rd Revised Date	Q4 Update
604	Pain Management	Andy Swinburn	Mar-25	• Closed in Quarter 4
621a	(Reported within Closed Session)	Jonny Sammut	Mar-25	• Closed in Quarter 4
624	IM&T Infrastructure	Jonny Sammut	Mar-25	• Closed in Quarter 4
657a	Records Management	Jonny Sammut	Mar-25	• Closed in Quarter 4
614	Senior Paramedic Role	Andy Swinburn	Mar-25	• Closed in Quarter 4
643	111 Commissioning Final Advisory Report	Rachel Marsh	Dec-24	• Closed in Quarter 4
683	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Andy Swinburn	Mar-25	• Action remains open – please see update below

Electronic Patient Clinical Records: Clinical Compliance Internal Audit

14. There are currently four open audit actions related to the **2023/24 Electronic Patient Clinical Records (ePCR): Clinical Compliance internal audit**, these are:

Action Ref:	Recommendation	Status
681	To confirm accuracy of the self-certification compliance rate, management should consider capturing the method of training delivery on ESR	Originally due for completion by June 2024. Third revised date (May 2025) applied during Quarter 4.
683	Management should consider including a test in ESR to confirm competency before successfully self-certifying.	Originally due for completion by June 2024. Currently on third revised date of March 2025 so is overdue.
684	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.	Originally due for completion by September 2024. Third revised date (May 2025) applied during Quarter 4.
686	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.	Originally due for completion by September 2024. Second revised date (September 2025) applied during Quarter 4.

15. Work undertaken during 2023 and 2024, particularly that associated with **clinical indicator improvements**, resulted in several modifications being made to the ePCR interface to improve data capture and encourage accurate completion of care records.
16. Whilst improvements have been made to the ePCR interface to improve data entry, clinician feedback suggested usability issues. The Trust's **Clinical Reference Group** therefore recommended an accompanying learning module be developed via LMS365; however, delivery has been delayed due to resource constraints in the Education and Training Team.
17. Originally assigned to the **Clinical Directorate**, the remaining four actions were reallocated in March 2025 to the **Digital Directorate**, with Jonny Sammut confirmed as Executive Lead and Keith Dorrington as Responsible Officer.
18. A meeting between the Digital Directorate and Internal Audit, facilitated by the Corporate Governance, is scheduled for June 2025 to determine the way forward. This may include deadline extensions or re-framing of the recommendations.
19. The open actions from the Cyber-Security and the Technical Resilience audit will be received in the closed session.

Internal Audit: – ARAC Actions (Annex 1)

20. In Quarter 4, two internal audit actions fell under ARAC's purview. Both related to the Risk Management internal audits undertaken in 2022/23 and 2023/24.
21. One of these audit actions was closed in quarter, which is 50% (compared to 75% in the previous quarter).
22. The remaining open action, Action 596 Risk Management, relates to development of risk appetite statements. A revised deadline of July 2025 has been set.

Action	Recommendation	Update
596	Following development of risk appetite matrix, develop and finalise risk appetite statement	- Risk appetite training session took place with the Board in December 2024. - Risk appetite workshop with the Board took place in February 2025 and good progress was made – beginning the work on finalising the risk appetite statements due for completion by the end of Quarter 2 (September 2025).

External Audit: - Full Tracker Review (Annex 2)

23. Of 13 open external audit actions in Quarter 4, 11 (85%) were closed in quarter following verification of evidence – this is a significant improvement from 29% reported in Quarter 3, and 28% in Quarter 2.
24. The two remaining open audit actions (151 and 152) relate to the 23/24 Review of Cost Saving Arrangements (Audit Wales Audit).
25. Both of these open audit actions are currently within their original date, with action 151 due for completion by June 2025 (Quarter 1), and action 152 due for completion by August 2025 (Quarter 2).
26. Recommendations from the **Quality Governance Review Follow-Up Audit (October 2024)** were reviewed by the Quality, Patient Experience and Safety Committee in March 2025. These audit actions will be included in the next iteration of the Audit Tracker and updates reported at the end of 2025/26 Quarter 1.
27. Actions from the **Welsh Risk Pool (WRP) Concerns Assessment 2024** will also be added to the Audit Tracker for updating in 2025/26 Quarter 1.

External Audit: – ARAC Actions

28. There are currently no external audit actions in the purview for this committee.

Management and Development of the Tracker

29. Upon receipt of each final internal audit report, the '**Audit Process and Reporting Handbook**' is shared with the respective management team(s) as a reminder to Directorates to review and update the tracker on a monthly basis.

30. The **Head of Compliance and Assurance** oversees Tracker updates, liaising and providing advice to directorates, validating closure evidence, and coordinating with the **Assistant Directors Leadership Team (ADLT)** to facilitate a further 'check and challenge', following this the Corporate Governance Team formally reports progress against the tracker to **Committees**.

31. The current version of the tracker is now open for Directorate review for actions due between April and June 2025. These 2025/26 Quarter 1 updates will be presented to this Committee in September 2025.

32. The Corporate Governance Team continues to work on the development of the SharePoint solution for Audit Tracker 3.0. Testing is planned during 2025/26 Quarter 1, followed by internal stakeholder engagement, demonstration/training and system implementation in Quarter 2.

33. Once Tracker 3.0 is in place, future reporting through Power BI will differentiate between Committee-level detail and the broader ARAC and Executive Leadership Team oversight.

34. Power BI support is in place to support the development of this reporting, and ARAC reconfirmed the reporting on the tracker approved, which will be as follows

(a) Number of substantial/reasonable/limited/no assurance/advisory audit reports per year.

Gives a general overview throughout the year and over audit years

(b) Number of audit reports per committee oversight

Gives a general overview of the spread of oversight of audit reports and those who may not be monitoring any reports

(c) *Number of high rated recommendations with actions more than 3 months past their original date*

High rated actions should be closed off as soon as practicable due to their risk profile. This will allow for escalations.

(d) *Number of actions for limited assurance audit reports more than 3 months past their original date*

Due to the issues that will arise in a limited assurance report they should be closed off asap and before follow-up reviews. This will allow for escalations.

(e) *Number of actions that have 'met' and 'not met' the original due date*

Gives an indication of the realistic nature of the original dates leading to a change in behaviour

Provides oversight of progress over audit years.

This may be similar as the table at paragraph 6 above.

(f) *Number of individual actions that have 'not met' revised dates*

Will indicate a potential issue in meeting an action or lack of progress for some other reason. Will need to be sure this is not a double count with some of the other metrics.

RECOMMENDATION

35. The Committee is asked to:

(a) Note the significant progress made in closing audit actions during Quarter 4;

(b) Note the ELT's decision to remove the option of a third revised deadline; and

(c) 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.

AGENDA ITEM No	9
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1st APRIL 2024 TO 31st MAY 2025

MEETING	Audit Committee
DATE	24 th June 2025
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 twelve months from 1st April 2024 to 31st March 2025 (Annex 1) and during the two months from 1st April 2025 to 31st May 2025 (Annex 2)
KEY ISSUES/IMPLICATIONS
Total net Losses and Special Payments made were as follows: - - period 1st April 2024 to 31st March 2025 £0.668m - period 1st April 2025 to 31st May 2025 -£1.248m

REPORT APPROVAL ROUTE
Audit Committee 24th June 2025 – no action required for information under SFI's only

REPORT APPENDICES

Annex 1 – Summary and details of payments made for the twelve months to 31st March 2025

Annex 2 – Summary and details of payments made for the two months to 31st May 2025

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 2024-31ST MARCH 2025 & 1ST APRIL 2025-31ST MAY 2025

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 twelve months from 1st April 2024 to 31st January 2025 (**Annex 1**) and the two months from 1st April 2025 to 31st May 2025 (**Annex 2**).

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2024 to 31st March 2025 amounted to £0.668 million and for the period 1st April 2025 to 31st May 2025 amounted to -£1.248 million.
4. This relates to actual payments made less reimbursements received from the Welsh Risk Pool (WRP) and does not relate to any adjustments made to the provision. During the twelve months to 31st March 2025 payments made exceeded reimbursements received by £0.688m. However, due a WRP reimbursement received in April 2025, during the two months to 31st May 2025 reimbursements exceeded payments by -£1.248m.
5. During April 2025 you will note WRP reimbursements amounted to £1.519m. The vast majority of the reimbursement related to one case amounting to £1.451m in relation to a medical negligence claim surrounding the handling and treatment provided by the crew in attendance.

RECOMMENDED

6. 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 12 months to 31st March 2025:

	£
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	206,422.27
November 2024	328,023.64
December 2024	50,002.72
January 2025	101,792.29
February 2025	36,227.13
March 2025	131,413.83
	£668,298.74

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	58,404.00	26,750.00	34,705.00	0.00	27,111.00	67,997.04	£263,233.84
Counsel fees	10,137.50	7,366.66	6,846.66	-1,100.00	945.00	6,540.00	2,500.00	14,246.70	0.00	0.00	2,250.00	6,255.00	£55,987.52
CRU	0.00	0.00	833.00	1,335.00	688.00	2,289.00	-833.00	0.00	0.00	766.00	1,510.00	2,253.00	£8,841.00
Damages	22,500.00	0.00	-36,079.00	376,710.00	49,125.00	46,069.00	126,254.00	224,926.00	75,896.33	27,200.00	35,900.20	19,050.00	£967,551.53
Defence Costs	45.92	967.74	14,442.55	25,512.80	7,202.55	5,355.43	5,565.50	17,521.78	30,514.40	21,706.81	-831.64	20,207.05	£148,210.89
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	5,745.00	£27,237.48
Vehicle Repairs	11,545.03	13,521.41	73,806.43	30,444.65	36,735.27	24,762.57	53,260.17	44,121.16	39,974.65	53,544.48	9,135.00	8,972.74	£399,823.56
WRP Refund	0.00	0.00	-975,394.24	0.00	-53,138.35	0.00	-39,628.40	0.00	-131,087.66	-1,425.00	-40,695.00	0.00	-£1,241,368.65
Property Repairs	0.00	540.00	1,200.00	32,860.00	42.00	0.00	900.00	458.00	0.00	0.00	1,847.57	934.00	£38,781.57
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	£206,422.27	£328,023.64	£50,002.72	£101,792.29	£36,227.13	£131,413.83	£668,298.74

20RT4MN0001	-	892,874.96	WSP Refund
TOTAL		668,298.76	

Welsh Ambulance Services University NHS Trust
Feb-25

Case Reference	Details	Amount (£)
23RT4PI0009	COUNSEL FEES	500.00
25RT4DP0178	TP VEHICLE REPAIRS	555.00
25RT4EG0046	TRANSCRIPTION COSTS	49.01
25RT4EG0047	TRANSCRIPTION COSTS	26.39
25RT4EG0048	TRANSCRIPTION COSTS	20.09
25RT4EG0049	TRANSCRIPTION COSTS	22.62
25RT4DP0180	TRANSCRIPTION COSTS	307.20
25RT4DP0181	TP VEHICLE REPAIRS	1,829.00
25RT4DP0183	TP VEHICLE REPAIRS	160.00
25RT4EG0049	PROFESSIONAL FEES	1,250.00
25RT4DP0184	DAMAGE TO PROPERTY	1,453.00
25RT4DP0185	TP VEHICLE REPAIRS	1,193.64
25RT4DP0186	TP VEHICLE REPAIRS	1,731.65
25RT4DP0187	TP VEHICLE REPAIRS	900.00
25RT4DP0188	DAMAGE TO PROPERTY	394.57
25RT4DP0189	TP VEHICLE REPAIRS	2,275.71
25RT4DP0110	TP VEHICLE REPAIRS	365.00
25RT4DP0190	TP VEHICLE REPAIRS	125.00
25RT4EG0038	PROFESSIONAL FEES	- 3,300.00
21RT4PI0026	CLAIMANTS SOLICITORS FEE	15,000.00
22RT4PI0047	GENERAL DAMAGES SETTLEMENT	22,000.00
22RT4PI0047	CLAIMANTS SOLICITORS FEE	7,892.00
22RT4PI0047	CRU	744.00
24RT4PI0056	GENERAL DAMAGES SETTLEMENT	10,100.20
22RT4GN0037	CLAIMANTS SOLICITORS FEE	1,920.00
23RT4GN0020	EXPERT WITNESS	3,800.00
24RT4PI0001	CRU	766.00
24RT4PI0006	CLAIMANTS SOLICITORS FEE	999.00
24RT4PI0029	COUNSEL FEES	500.00
24RT4MN0001	EXPERT WITNESS	2,000.00
25RT4MN0026	TRANSCRIPTION COSTS	43.05
23RT4PI0035	WRP REIMBURSEMENT	- 32,345.00
23RT4GN0026	WRP REIMBURSEMENT	- 4,500.00
24RT4GN0018	WRP REIMBURSEMENT	- 2,000.00
24RT4GN0024	WRP REIMBURSEMENT	- 350.00
24RT4GN0019	WRP REIMBURSEMENT	- 1,500.00
18RT4MN0016	CLAIMANTS SOLICITORS FEE	1,300.00
Totals		36,227.13

Welsh Ambulance Services University NHS Trust
Mar-25

Case Reference	Details	Amount (£)
21RT4PI0026	COUNSEL FEES	1,250.00
24RT4PI0041	COUNSEL FEES	400.00
16RT4MN0009	PROFESSIONAL FEES	2,717.00
24RT4MN0015	EXPERT WITNESS	1,710.00
25RT4MN0016	EXPERT WITNESS	1,800.00
25RT4MN0001	EXPERT WITNESS	360.00
25RT4EG0051	PROFESSIONAL FEES	650.00
25RT4DP0191	DAMAGE TO PROPERTY	934.00
25RT4EG0052	PROFESSIONAL FEES	8,500.00
25RT4EG0053	TRANSCRIPTION COSTS	134.89
25RT4EG0054	TRANSCRIPTION COSTS	45.92
25RT4EG0055	TRANSCRIPTION COSTS	1,000.00
25RT4EG0056	PROFESSIONAL FEES	1,000.00
25RT4EG0057	PROFESSIONAL FEES	1,500.00
25RT4EG0046	PROFESSIONAL FEES	1,821.45
25RT4EG0058	PROFESSIONAL FEES	2,423.95
25RT4MN0018	COUNSEL FEES	630.00
25RT4MN0031	TRANSCRIPTION COSTS	91.84
22RT4PI0038	CRU	744.00
22RT4PI0038	CLAIMANTS SOLICITORS FEE	40,000.00
24RT4PI0020	CLAIMANTS SOLICITORS FEE	14,495.20
24RT4PI0032	GENERAL DAMAGES SETTLEMENT	4,500.00
24RT4PI0032	CLAIMANTS SOLICITORS FEE	4,041.84
24RT4MN0005	GENERAL DAMAGES SETTLEMENT	8,750.00
22RT4GN0042	PROFESSIONAL SERVICES	1,100.00
21RT4MN0009	EXPERT WITNESS	825.00
24RT4MN0004	EXPERT WITNESS	1,050.00
25RT4DP0193	TP VEHICLE REPAIRS	4,999.62
25RT4DP0195	TP VEHICLE REPAIRS	803.72
24RT4PI0073	COUNSEL FEES	750.00
21RT4PI0026	CRU	743.00
24RT4PI0020	CRU	766.00
23RT4GN0022	GENERAL DAMAGES SETTLEMENT	- 2,500.00
22RT4PI0006	GENERAL DAMAGES SETTLEMENT	9,000.00
22RT4PI0006	CLAIMANTS SOLICITORS FEE	7,360.00
25RT4MN0001	COUNSEL FEES	3,225.00
25RT4DP0197	TP VEHICLE REPAIRS	3,169.40
23RT4GN0026	CLAIMANTS SOLICITOR FEES	1,000.00
24RT4GN0018	GENERAL DAMAGES SETTLEMENT	- 1,200.00
24RT4GN0019	GENERAL DAMAGES SETTLEMENTN	500.00
20RT4MN0008	COURT FEES	203.00
20RT4MN0018	COURT FEES	119.00
Totals		131,413.83

Welsh Ambulance Services University NHS Trust
Losses and Special Payments

Annex 2

Summary of payments for the two months to 31st May 2025:

	£
April 2025	-1,314,358.67
May 2025	66,430.59
April 2026	-
May 2026	-
April 2027	-
May 2027	-
April 2028	-
May 2028	-
April 2029	-
May 2029	-
April 2030	-
May 2030	-
	-£1,247,928.08

Losses and Special Payments Breakdown:

Payment Type	April		May		June		July		Aug		Sept		Oct		Nov		Dec		Jan		Feb		Mar		Total
	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£		
Claimants Solicitor Costs		139,680.80		50,036.56		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	189,717.36
Counsel fees		3,570.00		750.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	4,320.00
CRU		0.00		-2,412.50		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	-2,412.50
Damages		15,375.00		2,241.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	17,616.00
Defence Costs		12,678.08		-5,327.38		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	7,350.70
Expert Witness		11,405.00		2,930.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	14,335.00
Vehicle Repairs		21,074.64		18,212.91		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	39,287.55
WRP Refund		-1,518,526.19		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	-1,518,526.19
Property Repairs		395.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	395.00
Court Refund		-11.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	-11.00
Total		-£1,314,358.67		£66,430.59		£0.00		£0.00		£0.00		£0.00		£0.00		£0.00		£0.00		£0.00		£0.00		£0.00	-£1,247,928.08

Welsh Ambulance Services University NHS Trust	Key	
Losses and Special Payments	MN	Medical Negligence
	PI	Personal Injury
Summary of payments for the two months to 30th May 2025	DP	Damage To Property
	£	
DP cases < £1,000	7,844.84	17 cases
Redress cases < £1000	868.00	1 case
PI cases < £1000	944.00	1 case
25RT4MN0030	66.01	
26RT4MN0001	130.78	
25RT4MN0023	900.00	
25RT4MN0022	1,275.00	
25RT4MN0021	2,430.00	
25RT4MN0016	2,545.00	
25RT4MN0020	2,555.00	
22RT4MN0018	3,500.00	
24RT4MN0008	10,000.00	
18RT4MN0016	13,032.40	
23RT4MN0004	15,375.00	
18RT4MN0012	106,950.00	
24RT4PI0033	1,250.00	
26RT4PI0001	4,500.00	
24RT4PI0066	9,299.80	
24RT4PI0028	9,601.00	
21RT4PI0026	11,500.00	
22RT4PI0046	32,381.16	
24RT4GN0020	1,000.00	
22RT4GN0042	1,600.00	
23RT4GN0020	1,920.00	
26RT4GN0001	2,000.00	
23RT4GN0027	3,200.00	
23RT4GN0028	4,100.00	
26RT4DP0001	1,120.00	
26RT4DP0028	1,267.77	
26RT4DP0004	1,466.54	
26RT4EG0004	1,500.00	
26RT4DP0009	1,668.23	
26RT4DP0011	1,759.34	
26RT4DP0006	2,246.39	
26RT4EG0003	2,382.05	
26RT4DP0019	2,687.30	
26RT4DP0017	2,750.00	
26RT4DP0018	2,750.00	
25RT4EG0026	2,950.00	
26RT4DP0022	3,108.53	
26RT4DP0021	3,370.55	
26RT4DP0016	4,282.13	
26RT4DP0010	4,499.76	
26RT4DP0024	5,088.03	
22RT4MN0001	- 1,450,963.19	WRP REFUND
24RT4MN0009	- 35,913.00	WRP REFUND
20RT4MN0011	- 3,276.50	REFUND
21RT4PI0006	- 29,450.00	WRP REFUND
22RT4PI0006	- 19,985.00	WRP REFUND
20RT4PI0037	- 2,125.00	REFUND
24RT4PI0026	- 80.00	REFUND
23RT4GN0012	- 1,000.00	WRP REFUND
24RT4GN0038	- 800.00	WRP REFUND
Total	- 1,247,928.08	

Welsh Ambulance Services University NHS Trust
Apr-25

Case Reference	Details	Amount (£)
24RT4PI0033	COUNSEL FEES	1,250.00
22RT4MNO018	EXPERT WITNESS	3,500.00
25RT4MNO016	COUNSEL FEES	1,795.00
25RT4MNO020	EXPERT WITNESS	2,375.00
25RT4MNO020	EXPERT WITNESS	180.00
25RT4MNO021	EXPERT WITNESS	500.00
25RT4MNO022	COUNSEL FEES	525.00
25RT4MNO022	EXPERT WITNESS	750.00
25RT4MNO023	EXPERT WITNESS	900.00
25RT4MNO030	TRANSCRIPTION SERVICES	66.01
26RT4MNO001	TRANSCRIPTION SERVICES	130.78
21RT4PI0026	CLAIMANT'S SOLICITORS FEES	11,500.00
24RT4PI0066	CLAIMANTS SOLICITORS FEE	9,310.80
24RT4PI0066	REFUND	- 11.00
18RT4MNO012	CLAIMANTS SOLICITORS FEES	1,950.00
18RT4MNO012	CLAIMANTS SOLICITORS FEES	105,000.00
23RT4MNO004	GENERAL DAMAGES SETTLEMENT	15,375.00
24RT4MNO008	CLAIMANTS SOLICITORS FEES	10,000.00
23RT4GN0020	CLAIMANTS SOLICITORS FEE	1,920.00
23RT4GN0027	EXPERT WITNESS	3,200.00
26RT4DP0001	TP VEHICLE REPAIR	1,120.00
26RT4DP0002	TP VEHICLE REPAIR	340.00
26RT4DP0003	DAMAGE TO PROPERTY	395.00
26RT4DP0004	TP VEHICLE REPAIR	1,466.54
26RT4DP0005	TP VEHICLE REPAIR	845.00
25RT4EG0026	PROFESSIONAL FEES	2,950.00
26RT4EG0001	TRANSCRIPTION SERVICES	149.24
26RT4DP0006	TP VEHICLE REPAIR	2,246.39
26RT4EG0002	PROFESSIONAL FEES	750.00
26RT4DP0007	TP VEHICLE REPAIR	30.00
26RT4DP0008	TP VEHICLE REPAIR	851.56
26RT4DP0009	TP VEHICLE REPAIR	1,668.23
26RT4DP0010	TP VEHICLE REPAIR	4,499.76
26RT4DP0011	TP VEHICLE REPAIR	1,759.34
26RT4DP0012	TP VEHICLE REPAIR	504.78
26RT4DP0014	TP VEHICLE REPAIR	310.91
26RT4DP0015	PROFESSIONAL FEES	400.00
26RT4DP0016	TP VEHICLE REPAIR	4,282.13
26RT4EG0003	PROFESSIONAL FEES	2,382.05
26RT4DP0017	OMBUDSMAN FINE	2,750.00
26RT4DP0018	OMBUDSMAN FINE	2,750.00
26RT4EG0004	PROFESSIONAL FEES	1,500.00
22RT4MNO001	WRP REIMBURSEMENT	- 1,451,363.19
24RT4MNO009	WRP REIMBURSEMENT	- 35,913.00
21RT4PI0006	WRP REIMBURSEMENT	- 29,450.00
23RT4GN0012	WRP REIMBURSEMENT	- 1,000.00
24RT4GN0038	WRP REIMBURSEMENT	- 800.00
Totals		- 1,314,358.67

Welsh Ambulance Services University NHS Trust
May-25

Case Reference	Details	Amount (£)
22RT4PI0046	COSTS DRAFTMAN FEES	400.00
25RT4MN0016	COUNSEL FEES	750.00
25RT4MN0021	EXPERT WITNESS	1,930.00
26RT4DP0019	TP VEHICLE REPAIRS	2,687.30
26RT4EG0005	TRANSCRIPTION SERVICES	22.62
26RT4DP0020	TP VEHICLE REPAIRS	294.20
26RT4DP0020	TP VEHICLE REPAIRS	- 294.20
25RT4DP0173	TP VEHICLE REPAIRS	349.79
26RT4DP0021	TP VEHICLE REPAIRS	3,370.55
26RT4DP0022	TP VEHICLE REPAIRS	3,108.53
26RT4DP0023	TP VEHICLE REPAIRS	941.64
26RT4DP0024	TP VEHICLE REPAIRS	2,691.63
26RT4DP0024	TP VEHICLE REPAIRS	2,396.40
26RT4DP0025	TP VEHICLE REPAIRS	2,363.32
26RT4DP0025	TP VEHICLE REPAIRS	- 2,363.32
26RT4DP0026	TP VEHICLE REPAIRS	952.16
26RT4DP0027	TP VEHICLE REPAIRS	277.35
26RT4DP0027	TP VEHICLE REPAIRS	- 277.35
26RT4DP0028	TP VEHICLE REPAIRS	1,267.77
26RT4DP0029	TP VEHICLE REPAIRS	47.14
26RT4DP0030	TP VEHICLE REPAIRS	400.00
26RT4DP0031	CLAIMANTS SOLICITORS FEE	555.00
20RT4PI0037	REFUND	- 2,125.00
22RT4PI0006	REFUND	- 3,625.00
20RT4PI0014	CRU	944.00
22RT4PI0006	REFUND	- 9,000.00
22RT4PI0006	REFUND	- 7,360.00
22RT4PI0046	CLAIMANTS SOLICITORS FEES	31,981.16
24RT4PI0026	COURT FEE REFUND	- 80.00
24RT4PI0028	GENERAL DAMAGES SETTLEMENT	9,101.00
24RT4PI0028	GENERAL DAMAGES SETTLEMENT	500.00
26RT4PI0001	GENERAL DAMAGES SETTLEMENT	4,500.00
18RT4MN0016	CLAIMANTS SOLICITORS FEES	13,032.40
20RT4MN0011	CRU REFUND	- 3,276.50
22RT4MN0001	CLAIMANTS SOLICITORS FEES	400.00
22RT4GN0042	CLAIMANTS SOLICITORS FEES	1,600.00
23RT4GN0028	GENERAL DAMAGES SETTLEMENT	2,500.00
23RT4GN0028	CLAIMANTS SOLICIOTRS FEES	1,600.00
24RT4GN0020	EXPERT WITNESS	1,000.00
24RT4GN0033	CLAIMANTS SOLICITORS COSTS	868.00
26RT4GN0001	GENERAL DAMAGES SETTLEMENT	2,000.00
Totals		66,430.59



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AGENDA ITEM No	10
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

Updates to NHS Wales No PO No Pay Policy

MEETING	Audit, Risk and Assurance Committee
DATE	24 June 2025
EXECUTIVE	Chris Turley, Executive Director of Finance & Corporate Resources
AUTHOR	Edward Roberts, Interim Assistant Director of Finance
CONTACT	Edward.Roberts@wales.nhs.uk

EXECUTIVE SUMMARY

The all Wales No PO No Pay policy governs invoices which arrive in the system without an order number (unless on the approved exception list – see Appendix 1 in attached policy). These are then placed on hold and a weekly communication is emailed to the supplier who is instructed to seek an order number from the relevant department and manager before payment is made.

The aim is to drive up compliance with the Standing Financial Instructions as well as ensuring a more standard order management process.

The continued implementation of a national policy of 'No Purchase Order No Pay' is to be an essential and fundamental building block from which the efficiency and effectiveness of the Procure to Pay (P2P) process can be further developed.

This policy, which has been in place since September 2018, reviewed in September 2023 is now subject to a small number of proposed amendments. First drafted in June 2024, these have been through several national groups to be officially signed off and now is at the final stage being brought to this committee for WAST adoption and approval.

Summary of changes to the previously adopted policy:

- List of objectives increased to include reference to late payment fees and service disruption.
- Inclusion of references made to the 'exception list' throughout the document.
- Clarity of % compliance required for Public Sector Payment Policy.
- Removal of letter issued to supplier from appendices.
- Removal of escalation process tables to allow for this being determined locally.
- Updates to exceptions list in appendix 1.



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RECOMMENDATION:

The Committee is requested to receive and accept the changes to the National Policy and adopt and **APPROVE** this policy.

REPORT APPENDICES

NHS Wales No PO No Pay No Purchase Order No Payment Policy

REPORT CHECKLIST

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

NHS Wales Shared Services Partnership

NHS Wales No PO No Pay (No Purchase Order No Payment) Policy

*To be adopted by Each Health Board, Special
Health Authority and Trust in NHS Wales*

Contents:

1. Introduction	3
2. Policy Statement	3
3. Aims	3
4. Objectives.....	3
5. Scope.....	4
6. Roles and Responsibilities	5
7. Main Body.....	6
8. Non Compliance Policy	8
9. Training	9
10 Implementation.....	9
11 Audit.....	9
12 Review.....	9
Appendix 1 – Exceptions to the No PO No Pay Policy.....	10

1 Introduction/Overview

The P2P - the Procure to Pay process – encompasses the end-to-end process from sourcing goods and services through to delivery and receipt of goods and payment to the supplier. A No PO No Pay policy is where invoices arriving in the system without an order number (unless on the approved exception list – see Appendix 1) are placed on hold and a weekly communication is emailed to the supplier who is instructed to seek an order number from the relevant department and manager that was supplied before payment is made. The aim is to drive up compliance with the Standing Financial Instructions as well as the standard order management process.

2 Policy Statement

The implementation of a national policy of 'No Purchase Order No Pay' is to be an essential and fundamental building block from which the efficiency and effectiveness of the P2P process can be developed.

3 Aims/Purpose

To ensure:

- That all goods and services are ordered appropriately and are supported by official Purchase Orders in line with LHB, Trust and Special Health Authority Standing Financial Instructions.
- Efficient processes are put in place so that goods are delivered when required.
- Costs are controlled by:
 - Ensuring all non-pay expenditure incurred by the organisation is valid and appropriately authorised in advance of the goods/services being received.
 - Minimising transactional costs associated with payment for goods.
 - Paying supplier invoices within deadlines set by Welsh Government.
 - Maximising financial incentives for early payment offered by suppliers.
 - Reducing the risk of late payment interest and fees being charged by suppliers.

4 Objectives

This policy seeks to ensure that NHS Wales only pays for goods, services and works which have been properly ordered and authorised in accordance with the NHS Wales Procurement rules and Standing Financial Instructions. It also ensures invoices received by the NWSSP Accounts Payable teams can be processed efficiently to minimise delay in payments to suppliers and contractors. Invoices received by the NWSSP Accounts Payable Team without a valid PO number will severely delay payment to the suppliers. Successful adoption of this policy will lead to the following benefits:

- Better control environment – the correct level of authorisation of purchase orders, in advance of expenditure being incurred.
- Catalogue compliance will be improved leading to less off catalogue purchasing and lead to revenue savings.
- More comprehensive procurement intelligence being captured through the system about what and where goods and services are purchased allowing for better sourcing decisions.
- Costs will be more accurately accrued by the system reducing management accounting and Accounts Payable (AP) team workload.
- Public Sector Payment Policy compliance will improve because processing times reduce.
- Early payment discounts can be maximised.
- Overall processing costs in NWSSP P2P will reduce, releasing resources for NHS Wales.
- Suppliers will be paid on time thus supporting the wider economy.
- Less late payment interest and fees will be charged.
- Supplies of goods / services will not be disrupted or stopped due to late payment of invoices.

5 Scope

This policy is relevant to the following groups of staff within NHS Wales Health Boards, Special Health Authorities, Trusts and NHS Wales Shared Services Partnership:

- **Requisitioners**
Those staff that process requisitions for goods and services in departments and directorates within NHS Wales.
- **Approvers/Budget Holders**
Those staff that approve requisitions for goods and services in departments and directorates within NHS Wales.

- ***Staff that Receive Goods/Services***

Those staff that indicate within the Oracle or other ordering systems that the goods/services ordered have been received.

- ***Procurement Staff***

All NWSSP Procurement staff in the Procurement Directorate.

- ***Accounts Payable Staff***

All NWSSP Accounts Payable staff involved in the invoice payment process.

- ***Finance Departments***

All staff involved in financial management.

6 Roles and Responsibilities

6.1 All Staff with Responsibility for Ordering

It is the responsibility of all staff, designated under the local scheme of delegation, that order goods and services to ensure that a Purchase Order number is provided to a supplier in advance of the goods or services being supplied. If the goods/services being ordered are on the Exception list, then all staff must ensure they are aware of the correct payment authorisation process for those goods/services.

6.2 Requisitioners

All staff that raise requisitions for goods and services must ensure a Purchase Order number is provided to a supplier in advance of the goods or services being supplied. If the goods/services being ordered are on the Exception list, then all staff must ensure they are aware of the correct payment authorisation process for those goods/services.

6.3 Requisition Approvers/Budget Holders

All managers and budget holders designated to approve requisitions for goods and services must ensure a Purchase Order number is provided to a supplier in advance of the goods or services being supplied. It is their responsibility to ensure the person raising the order has sufficient information to be able to do so, and knowledge of when the goods / services are received to be able to update the system accordingly. If the goods/services being ordered are on the Exception list, then all managers and budget holders must ensure their staff are

aware of the correct payment authorisation process for those goods/services. These invoices will come in requiring Authorisation and be put on an Awaiting Authorisation hold. Any invoice not classed as an exception and does not quote a valid PO number will be subject to a non-compliance escalation procedure.

6.4 Staff who 'Receipt' Goods and Services

All staff that work in central stores, receipt and distribution points and local departments where goods are delivered, or services are received have responsibility for recording the goods/services as being received. They must ensure that the Purchase Order is marked as 'received' as soon as possible within the Oracle system within 2 working days following delivery of goods or provision of the service.

6.5 Procurement Services Staff

All staff working within NWSSP Procurement Services will engage with Health Board/Trust/SHA accountable Budget Holders to ensure that this policy is adopted and adhered to by all HB/Trust/SHA staff and that local operational procedures for supporting the No PO No Pay Policy are observed at all times. Procurement Services will ensure training and awareness of the Policy with Key HB/Trust/SHA stakeholders.

6.6 Accounts Payable Staff

All staff that process the payment of invoices within NWSSP Accounts payable must ensure that no invoice is paid (unless it is identified as an exception in Appendix 1) if a Purchase Order number is not quoted on the invoice. All invoices received with no Purchase Order number must be recorded within the Oracle system and the supplier notified in accordance with the communications shown in Section 8. The invoice will be placed on a No PO No Pay hold and marked as disputed.

6.7 Finance Staff

The Finance P2P Lead in each Organisation must promote this policy to finance staff, requisitioners, approvers, budget holders & receptors within their Organisations.

Finance staff must ensure there are processes in place to capture data on invoices received but unpaid, that have no Purchase Order, so that expenditure can be accrued if necessary.

7 Operation of the Policy

7.1 How does No PO No Pay Work?

No PO No Pay policy operates by requiring all invoices submitted by suppliers to contain an official PO number. In all but agreed exceptional circumstances the PO number will be:

- Generated from NHS Wales Oracle Ordering system or
- Generated from other local ordering systems e.g. pharmacy; and
- Given to the supplier or contractor BEFORE making any commitment to spend NHS Wales's monies.

There are a number of categories of expenditure that are excluded from the policy which are shown in Appendix 1.

Any invoice received by the Accounts Payable Team that is not on the exception list and does not quote a valid PO number will incur processing and approval delays which could result in severe delays to supplier payment. Exceptions will be reviewed and amended from time to time and users notified of the amendments accordingly.

7.2 What constitutes a Valid PO?

An exercise will be undertaken to remind suppliers of the NHS Wales No PO No Pay Policy and reinforce that they must not, under any circumstances, accept any verbal or written order from NHS staff unless a valid PO number is given or there is an agreed exception as set out in Appendix 1.

Any invoice received that does not quote a valid PO number will be placed on hold until a valid PO number is provided.

7.3 What is a Valid PO number?

Valid PO numbers are generated from NHS Wales ordering systems as follows:-

- Oracle Financial and Procurement System
 - Oracle is the standard financial system used by NHS LHBs/Trusts/SHAs in Wales.
- Oracle via Basware

-
- This is an electronic exchange linked to Oracle for the electronic transmission of purchase orders.
 - Oracle EBS via GHX
 - This is an electronic exchange linked to Oracle for the electronic transmission of purchase orders.
 - The Pharmacy system used for generating pharmaceutical orders.

7.4 Submission of invoice

The Purchase Order will confirm which address invoices need to be submitted for payment. Some invoices will be submitted through the electronic exchanges or via the OCR process.

7.5 Public Sector Payment Policy

Provided a supplier has quoted a valid Purchase Order number which has been obtained in advance of supply, NHS Wales commits to paying invoices in line with the Public Sector Payment Policy i.e. within 30 days from the later of the receipt of goods or services or receipt of a valid invoice [not the invoice date].

All NHS Wales organisations are required by Welsh Government to be at least 95% compliant with this policy. Compliance is reported quarterly to Welsh Government, and annually in the Organisation's annual financial accounts.

7.6 Notification to Supplier of No PO on Invoice

If a supplier sends an Invoice without a Purchase Order number quoted and it does not sit within the agreed exception list, Accounts Payable will email the supplier weekly to inform them that their invoice has been placed on hold and that the supplier must contact the Health Organisation and request a Purchase Order number to be given to them. The supplier will be reminded of outstanding invoices awaiting confirmation of a Purchase Order every time the No PO No Pay report is run.

8 Non-Compliance

Non-compliance with this policy results in non-compliance with the Organisation's Standing Financial Instructions. The method of dealing with non-compliance will be for each organisation to determine but may include:

- Retraining of member of staff
- Escalation to senior management
- Escalation to Audit Committee (or equivalent)
- Escalation to Board

-
- Removal of access rights to the Oracle system

9 Training

Training resources aimed at the key staff affected by this policy have been developed and iProcurement training can be provided upon request from the NWSSP e-Enablement team.

10 Implementation

The No PO No Pay policy was implemented across NHS Wales on the 1st September 2018. In accordance with clause 12 below, the latest formal review of the Policy has been undertaken in June 2024 and the proposed changes/amendments to it will be adopted by all NHS Wales Organisations

11 Audit

The application of this policy will be subject to internal audit review as part of the NWSSP Accounts Payable audits.

12 Review

This policy was implemented in September 2018, reviewed in September 2023 with further amendments in June 2024 and is due for further review in June 2027.

APPENDIX 1

All Wales Exceptions to the No PO No Pay Policy

The following items are exceptions and do not require a valid PO number. This includes a number of areas where local ordering systems are in place with appropriate authorisation control processes that do not require an Oracle PO to be raised.

	ALL WALES EXCEPTIONS
Barrister Fees	Yes
Blue Badges	Yes
Bunkered Fuel & Fuel Cards	Yes
Capital Construction contracts (where approval outside of Oracle)	SBU only
CHC - FNC	Yes
CHC/Nursing Home Payments	Yes
Collaborative Fees (GPs)	Yes
Estates (Grammes/Studio 3 Feed)	BCU & WAST only
Eye Tests	Yes
Fleet vehicles (Chevin Feed)	WAST only
GP Loads (Drugs)	Yes
Grants	Yes
HMRC	Yes
Hospital Car service	Yes
Lease Car repairs	Yes
Local Government/Authorities including Business Rates	Yes
Losses & Compensation including Redress	Yes
NHS Organisations excluding NHS Supply Chain	Yes
Nurse agency	Yes
Orthotics	Yes
Patient reimbursements including patients travelling	Yes
Petty Cash	Yes
Pharmacy (including home deliveries ordered through pharmacy system)	Yes
Primary Care contracts OOHs	Yes
Primary care Low vision - HESP forms	Yes
Public Finance initiative	Yes
Purchase/Procurement Card	Yes
Telephone Landline - Line Rental, Call Charges & Maintenance	Yes
Telephone - Mobile Phone Charges	Yes
Salary deductions	Yes
Salary Sacrifice Schemes	Yes

Same day couriers	Yes
Tax, NI & Superannuation	Yes
Taxi Patient transport	WAST & NWSSP only
TV & Music Licences	Yes
Utilities (Gas, Electricity, Water and Oil heating)	Yes
Work Permits/Certificate of Sponsorship	Yes



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AGENDA ITEM No	11
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	0

**INTEGRATED GOVERNANCE PROGRAMME:
THE DYNAMIC INTEGRATED SYSTEM OF GOVERNANCE AND OVERSIGHT**

MEETING	Audit, Risk and Assurance Committee
DATE	24 June 2025
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary
AUTHOR	Trish Mills, Director of Governance / Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Trust is undertaking an ambitious integrated governance programme aimed at enhancing governance structures from floor to board.
2. The integrated governance programme aims to streamline and unify the mechanics and dynamics of governance across the Trust. A set of simplified governance principles that can be applied to the existing, maturing, and emerging elements of WAST's governance, accountability, risk and assurance frameworks is central to the programme. This will support openness and transparency, efficiency, and accountability at all levels from 'floor to board'
3. In March 2025 ARAC received the first part of the integrated governance programme which was the corporate governance framework map and tiering principles. This has now been communicated to the organisation and is in use.
4. This paper updates the committee on programme progress and outlines the planned deliverables for 2025/26. There are no issues requiring escalation, though further assurance opportunities are scheduled for December 2025 and March 2026.
5. The programmes of work for 2025/26 are:
 - Quarter 1: Develop a new board, committee, organisational governance front cover and SBAR template; develop writing and presentation guidance to accompany this; and develop a LMS365 or cameo PowerPoint on AAA preparation and the use of new front covers
 - Quarter 2: Meeting etiquette guidance; house style minutes
 - Quarter 3: Accountability, assurance and governance handbook
 - Quarter 4: AI for governance

RECOMMENDATION

6. Members are asked to receive assurance on progress of the programme and note the timelines for the 2025/26 deliverables

KEY ISSUES/IMPLICATIONS

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

REPORT APPROVAL ROUTE

N/A

REPORT APPENDICES

N/A

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	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

INTEGRATED GOVERNANCE PROGRAMME: THE DYNAMIC INTEGRATED SYSTEM OF GOVERNANCE AND OVERSIGHT

SITUATION

1. This paper updates the committee on the progress of the integrated governance programme following the initial paper in March 2025. That paper set out the shape that was being put on the framework and the development of standards for its operation and implementation across the Trust.

BACKGROUND

2. Board and committee governance has been significantly improved over the past 2-3 years as evidenced through positive Structured Assessments and a good programme of committee effectiveness reviews. The Corporate Governance team has now turned its attention to enhancing governance structures at levels beneath the board and replicating that the principles of good governance developed for the board.
3. The integrated governance programme was an IMTP deliverable for 2024/25 and the following outputs were designed and delivered:
 - Mapping of governance structures floor to board as a single source of truth. This was presented to ARAC in March 2025.
 - Development of a legislative universe with a compliance prioritisation audit commenced. This forms the basis for future work to support policy and audit.
 - Digitised Corporate Governance Standard Operating Procedure. Currently in use by the board and committee secretariat, but the vision is roll this out in a 'lite' version more widely.
4. The benefits and next steps for the programme are outlined in this paper and will be delivered over the next 2-3 years.

ASSESSMENT

5. The first step in the programme was the mapping of the governance forums currently in place. This was done through discussions with directors and their teams, knowledge gleaned through reporting to the board and Executive Leadership Team (ELT), and through the Corporate Governance team's participation in these forums. We continue to build on this as new forums are established. The corporate governance framework mapping can be accessed [Miro Board IGP](#). This has been communicated to the organisation.

6. The integrated governance programme aims to streamline and unify the mechanics and dynamics of governance across the Trust. A set of simplified governance principles that can be applied to the existing, maturing and emerging elements of WAST's governance, accountability, risk and assurance frameworks is central to the programme. This will support openness and transparency, efficiency, and accountability at all levels from 'floor to board.'
7. Significant work remains to ensure that the underlying mechanics and dynamics function in a cohesive and efficient manner. While not a formal IMTP deliverable for 2025/26, the following outlines the programme of work, incorporating changes to operating arrangements arising from last year's effectiveness reviews:

Deliverable	Desired Outcomes	Progress
Quarter 1 Develop a new board, committee, organisational governance front cover and SBAR template. Develop writing and presentation guidance to accompany this. LMS365 on AAA preparation	➤ Unified presentations across all forums aligned to our strategic objectives and duty of quality, setting a consistent tone and focus. ➤ Writing guidance will ensure that materials are developed with a clear understanding of what needs to be emphasised, particularly in executive summaries and then how to present those pertinent points. ➤ Clarity on impact assessments required to make decisions will promote better compliance with regulatory requirements and mitigate adverse impacts. ➤ Setting word counts and formatting makes the document easier to read and more accessible. This standardisation aids in reducing information overload and ensures key points are communicated effectively.	➤ Front covers and writing guidance developed ➤ Feedback on both received from NEDs ➤ Implementation plan finalised and commenced ➤ Aim to start use of new templates by 1 August
Quarter 2 Develop meeting etiquette guidance to include: - Scheduling and invitations - Professional conduct - Recording and Documentation - Chat and camera functions	➤ The development of meeting etiquette guidance will enhance the efficiency and inclusivity of our organisational interactions. ➤ By establishing clear protocols for scheduling and invitations, we ensure that meetings are planned with consideration for all participants' schedules and commitments. ➤ Guidelines on professional conduct will foster a respectful and collaborative atmosphere, essential for productive discussions.	➤ Guidance draft developed ➤ Information Governance Steering Group reviewing the issues of retention of meeting recordings ➤ Minutes house style draft developed and being socialised for feedback ➤ High level feedback received from NEDs

Deliverable	Desired Outcomes	Progress
- Meeting management - Follow-up and documentation - Access (languages, subtitles) Develop minutes house style	➤ Recording and documentation procedures will guarantee that valuable insights and decisions are captured accurately and are easily accessible for future reference. ➤ Effective meeting management will streamline discussions, ensuring they are focused and time efficient. Additionally, follow-up procedures will confirm that action items and responsibilities are clearly communicated and tracked post-meeting. ➤ Incorporating access features such as multiple languages and subtitles will make meetings more inclusive, enabling full participation from all members regardless of language barriers, thus enriching collaboration and enhancing overall communication within WAST. ➤ A 'minutes house style' for board and committees, as well as guidance for other tiers in the organisation provides consistency, clarity and accessibility, efficiency, improved accountability and better storage and search functionality.	
Quarter 3 Accountability, assurance and governance handbook	➤ The Integrated Governance Handbook complements the integrated governance mapping, providing clear and effective principles for our governance, accountability, risk, and assurance frameworks. ➤ The handbook outlines our organisational policies, from standing orders to board dynamics, while fostering a culture of autonomy, belonging, and contribution. It aligns all governance activities from floor to board, clarifies the nature and application of assurance, upholds transparency, and encourages continuous improvement. ➤ Enhanced by a variety of helpful annexes, the handbook offers vital educational and training resources to bolster governance capabilities at all levels.	➤ Draft commenced
Quarter 4 AI for governance	➤ AI, managed within a secure platform at WAST, will bring a number of efficiency gains. With the initial roll out aimed at	➤ Already in use for a number of forums

Deliverable	Desired Outcomes	Progress
	usual meeting artifacts such as minutes, AAA reports and actions and decisions. ➤ Future rollouts could include how to use AI in writing, analysis and presentation of key points. ➤ Dependency: Enterprise AI (co-pilot or Chap GPT) being rolled out more widely at WAST. Currently co-pilot is limited to a few and Chat GPT is not yet secure enough to use widely.	➤ 'Promptathons' taking place for use I minutes etc ➤ Outcomes to be incorporated into minutes and writing guidance

8. The meeting etiquette guidance and minutes house style will be presented to the December 2025 ARAC meeting, and the accountability, assurance and governance handbook will be presented at the March 2026 meeting, however there will be engagement with members on content ahead of those meeting where possible.
9. Work to be planned for 2026/27 or sooner includes:
 - Finalise tiering principles and implementation/communication plan
 - Version control and rules of engagement for Miro
 - Alignment of nomenclature of governance forums
 - Sector benchmarking
 - Terms of reference repository and alignment document
 - Effectiveness (lite) for operational and other governance forums
 - Roll-out board governance SOP (lite) for operational and other governance forums
 - With the digital team, determine standardisation of meeting artifacts
 - Education and training plan

RECOMMENDATION

10. The recommendation(s) are as set out in the executive summary.

AGENDA ITEM No	12
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	0

Non-compliance with Standing Orders: Ex-gratia payment approval

MEETING	Audit, Risk and Assurance Committee (ARAC)
DATE	24 June 2025
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. It is necessary for the Audit, Risk and Assurance Committee (ARAC) to be made aware of non-compliance with the Standing Orders. It is for the committee to formally consider the matter and make proposals to the board on any action to be taken, as required. This paper presents two matters of non-compliance with the Standing Orders which has recently been considered by the Remuneration Committee.
2. The matters relate to the approval of settlement agreements for two employees in respect of employment tribunal cases. Due to an internal oversight, approval in each of these cases was not sought from the Chief Executive, Remuneration Committee or Welsh Government prior to entering into settlement negotiations. The relevant standing orders were therefore not applied. The relevant standing orders, including the Terms of Reference of the Remuneration Committee are: -
 - 2.1 Table B of the [Scheme of Reservation and Delegation at 2.3\(e\)](#) provides for the Chief Executive to approve losses and special payments up to £50K, and the Director of People to approve up to £10k; however the Remuneration Committee Terms of Reference indicate that the Committee must approve all novel employment and pay cases, such as settlement agreement, overtime payment and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered. A settlement payment is treated as a 'special payment' in line with Chapter 6 Welsh Government finance Manual for Accounts, and as such requires the final approval of Welsh Government.



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3. In September 2024 approval was sought for Legal & Risk Services to enter negotiations for early settlement offers for both cases within the agreed levels of authority for special compensation payments under legal obligation, authorised by the Director of People and Culture (at that time) up to £20,000 per case. This approach was also later supported by the Director of People, Carl Kneeshaw, and signed via a COT3 agreement in February 2025.
4. The agreements were therefore treated as compensation payments under legal obligation as opposed to ex-gratia payments, which required approval by the Chief Executive, Remuneration Committee and Welsh Government. This was an error, and as such approval was not sought in line with the requirements of the standing orders ahead of entering into settlement negotiations / making payments for these cases.
5. Once this occurrence of non-compliance became known, and on advice from the Director of Corporate Governance/Board Secretary, retrospective approval was sought from the Remuneration Committee. The matter was taken and retrospectively approved at its meeting on the 03 June 2025. The ARAC is asked to note this matter of non-compliance with the standing orders.
6. The Director of People provided assurance to the committee that adjustments to internal controls have been made which will ensure that this does not reoccur. All future settlement agreements will be reviewed by the Chief Executive as well as the Director of People, and approval will always be sought by the Remuneration Committee before negotiations / agreements are finalised.
7. **RECOMMENDATION:**
The Committee is asked to note the position with non-compliance against Standing Orders and mitigating actions taken regarding the non-compliance reported to the Remuneration Committee in June 2025. The board will be notified via the ARAC AAA report.

KEY ISSUES/IMPLICATIONS
n/a
REPORT APPROVAL ROUTE
n/a
REPORT APPENDICES
n/a



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



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AGENDA ITEM No	13
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

2024/25 ANNUAL ACCOUNTS

MEETING	Audit, Risk & Assurance Committee
DATE	24 June 2025
EXECUTIVE	Executive Director of Finance & Corporate Resources
AUTHOR	Jessica Price, Head of Financial Accounting
CONTACT	Chris Turley chris.turley2@wales.nhs.uk

EXECUTIVE SUMMARY

The Trust submitted its unaudited draft Annual Accounts for 2024/25 to the Welsh Government, on 2nd May 2025, in line with the agreed timetable.

The accounts for the year ended 31st March 2025 have been prepared to comply with International Financial Reporting Standards (IFRS) adopted by the European Union, in accordance with HM Treasury's FReM by the Welsh Ambulance Services NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed.

The draft accounts have been subject to a detailed audit by Audit Wales, as described within this paper, and amended where required.

RECOMMENDED: That the Committee recommends that the Trust's Annual Accounts for 2024/25 be approved by the Trust Board, at its meeting on 26th June 2025.

KEY ISSUES/IMPLICATIONS

The final audited accounts (**Appendix 1**) as presented demonstrate that the Trust has:

- a retained surplus of £0.070 million for the 2024/25 financial year;
- Met its financial duty to break even over the 3 years 2022/23 to 2024/25.
- Expended Capital Investment funds of £20.321 million (including IFRS16 leases funding), thereby utilising 100% of the Trust's Welsh Government set Capital Expenditure Limit;
- Achieved Public Sector Payments Policy (PSPP) of 97.7% within 30 days against the 95% target.



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The requirement to achieve the administrative External Financing Target was again suspended for 2024/25.

REPORT APPROVAL ROUTE

An update on the financial performance of the Trust as at Month 12 2024/25 and therefore the draft 2024/25 year end position (subject to audit) was provided to both the Finance & Performance Committee on 20th May 2025 and Trust Board on 29th May 2025.

The audited Annual Accounts are to be presented to Trust Board for their approval on 26th June 2025.

The final approved and audited Annual Accounts are due to be submitted to Welsh Government by 30th June 2025 together with the Trust's Annual Report, as a single unified document in line with the agreed timetable.

REPORT APPENDICES

Appendix 1 – Annual Accounts 2024/25

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

2024/25 ANNUAL ACCOUNTS

SITUATION

1. The Trust submitted its unaudited 2024/25 Draft Accounts on 2nd May 2025 to the Welsh Government, in line with the agreed timetable.

BACKGROUND

2. The accounts for the year ended 31st March 2025 have been prepared to comply with International Financial Reporting Standards (IFRS) adopted by the *European Union, in accordance with HM Treasury's FReM by the Welsh Ambulance Services NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed.

**Please note that following the withdrawal of the UK from the European Union this position is unchanged.*

ASSESSMENT

3. The Final Audited Accounts (**Appendix 1**) as presented demonstrate that the Trust has:
 - a) As per the draft accounts, continued to report a retained surplus of £0.070 million for the year;
 - b) Under the National Health Services (Wales) Act 2006 the financial obligations of the NHS Trust contained within Schedules 4 2(1) and 4(2) are that:-
 - The Trust is required to achieve financial breakeven over a rolling 3-year period.
 - Welsh Health Circular WHC/2016/054 replaced WHC/2015/014 'Statutory and Financial Duties of Local Health Boards and NHS Trusts' and further clarifies the statutory financial duties of NHS Wales bodies.

- The Trust is therefore deemed to have met its financial duty to break even over the 3 years 2022/23 to 2024/25 as shown below.

Annual Financial Performance

	2022-23	2023-24	2024-25	2022-23 to 2024-25 Financial duty £000
	£000	£000	£000	
Retained surplus	62	85	70	217
Less Donated asset / grant funded revenue adjustment	0	0	0	0
Adjusted surplus/ (Deficit)	62	85	70	217

- c) External Financing Limit (EFL); the requirement to achieve the administrative External Financing Target has again been suspended for 2024/25.
 - d) Expended Capital Investment funds of £20.321 million, thereby utilising 100% of the Trust's Welsh Government set Capital Expenditure Limit; and
 - e) Achieved Public Sector Payments Policy (PSPP) of 97.7% within 30 days, against the 95% target.
4. To aid discussion and understanding, it is also planned that some of the key financial values within the accounts will be presented to Audit, Risk and Assurance Committee, along with explanations for any of the key movements from the previous financial year.
 5. The draft accounts have subsequently been audited by the Audit Wales (AW) team and, where required, amended by the Trust. Adjustments between draft and final accounts were largely presentational in nature or impacted only on a small number of the disclosures or notes to the accounts and did not result in a change to the retained surplus position.
 6. The financial statements are free of material misstatements; there are a small number of corrected misstatements, details of which have been included within the report provided by AW (ISA 260).
 7. Within the report provided by AW (ISA 260) it is indicated that it is the intention of the Auditor General for Wales to issue an unqualified certificate and report on the 2024/25 financial statements, citing that they provide a true and fair view of the Trust's finances in the 2024/25 financial year.



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8. The audited accounts are due to be presented to Trust Board for their approval on 26th June 2025.
9. The final approved and audited annual accounts and accountability report are then due to be submitted to Welsh Government by 30th June 2025 as one single unified document in line with the agreed timetable.

RECOMMENDED: That the Committee recommends that the Trust's Annual Accounts for 2024/25 be approved by the Trust Board, at its meeting on 26th June 2025.

Welsh Ambulance Services University NHS Trust

Foreword

These accounts for the period ended 31 March 2025 have been prepared to comply with International Financial Reporting Standards (IFRS) adopted by the European Union, in accordance with HM Treasury's FReM by Welsh Ambulance Services University NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed.

Statutory background

The Trust was established in 1998. Spread over an area of almost 8,000 square miles and serving a population of over 3 million, our diverse area encompasses tranquil rural retreats, busy seaside resorts and large urban boroughs.

Our varied and modern services are tailor-made for each community's differing environmental and medical needs, from cycles to fast response cars, frontline ambulances and nurses in our control centres.

We attend more than 250,000 emergency calls a year, over 50,000 urgent calls and transport over 1.3 million non-emergency patients to over 200 treatment centres throughout England and Wales.

Our dedicated staff are our biggest asset, and we employ in the region of 4,000 people. Approximately 70% of our workforce is within our emergency medical services which include our Clinical Contact Centres, and around 640 staff work in our Non-Emergency Patient Transport Service (NEPTS). Our patient facing services are also supported by colleagues working within our corporate and support functions (approximately 500 staff) and our valued extended volunteer workforce, including over 1,000 Community First Responders (CFRs) and circa 300 Volunteer Car Drivers.

We operate from over 90 ambulance stations, three contact centres, four regional offices and three vehicle workshops.

We also have our own National Training College to ensure our staff remain at the top of their game and receive regular professional development.

We provide access to high quality, on-going training, regular continuous professional development opportunities and personal annual development reviews.

We also provide the NHS Wales 111 service, a 24 hour health advice and information service for the public and the front end call handling and clinical triage elements of the GP out-of-hours services.

Performance Management and Financial Results

This Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2024-2025. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three year duty, with the first assessment of this duty in 2016-2017.

Under the National Health Services (Wales) Act 2006 the financial obligations of the NHS Trust are contained within Schedules 4 2(1) and 4 2(2). Each NHS trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to the revenue account. The first assessment of performance against the 3-year statutory duty under Schedules 4 2(1) and 4 2(2) was at the end of 2016-2017, being the first three year period of assessment.

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2025

	Note	2024-25 £000	2023-24 £000
Revenue from patient care activities	3	314,362	292,035
Other operating revenue	4	9,229	13,115
Operating expenses	5.1	(324,956)	(306,358)
Operating (deficit)/surplus		(1,365)	(1,208)
Investment revenue	6	1,400	1,253
Other gains and losses	7	375	432
Finance costs	8	(340)	(392)
Retained surplus	2.1.1	70	85
Other Comprehensive Income			
Items that will not be reclassified to net operating costs:			
Net gain/(loss) on revaluation of property, plant and equipment		243	996
Net gain / (loss) on revaluation of right of use assets		0	0
Net gain/(loss) on revaluation of intangible assets		0	0
Movements in other reserves		149	(18)
Net gain/(loss) on revaluation of PPE and Intangible assets held for sale		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Impairments and reversals		(436)	(333)
Transfers between reserves		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		(44)	645
Items that may be reclassified subsequently to net operating costs			
Net gain/(loss) on revaluation of financial assets held for sale		0	0
Sub total		0	0
Total other comprehensive income for the year		(44)	645
Total comprehensive income for the year		26	730

The notes on pages 6 to 76 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2025

		Note	31 March 2025	31 March 2024
			£000	£000
Non-current assets	Property, plant and equipment	13	100,372	96,107
	Right of Use Assets	13.3	8,830	12,367
	Intangible assets	14	3,662	5,232
	Trade and other receivables	17.1	401	388
	Other financial assets	18	0	0
	Total non-current assets		113,265	114,094
Current assets	Inventories	16.1	2,114	2,119
	Trade and other receivables	17.1	15,163	17,275
	Other financial assets	18	0	0
	Cash and cash equivalents	19	8,036	17,085
			25,313	36,479
	Non-current assets held for sale	13.2	0	0
	Total current assets		25,313	36,479
Total assets			138,578	150,573
Current liabilities	Trade and other payables	20	(29,488)	(37,482)
	Borrowings	21	(1,900)	(3,448)
	Other financial liabilities	22	0	0
	Provisions	23	(4,617)	(5,924)
	Total current liabilities		(36,005)	(46,854)
Net current assets/(liabilities)			(10,692)	(10,375)
Total assets less current liabilities			102,573	103,719
Non-current liabilities	Trade and other payables	20	0	0
	Borrowings	21	(5,890)	(7,897)
	Other financial liabilities	22	0	0
	Provisions	23	(6,580)	(6,387)
	Total non-current liabilities		(12,470)	(14,284)
Total assets employed			90,103	89,435
Financed by Taxpayers' equity:				
	Public dividend capital		80,343	79,701
	Retained earnings		(3,294)	(3,366)
	Revaluation reserve		13,054	13,100
	Other reserves		0	0
	Total taxpayers' equity		90,103	89,435

The financial statements were approved by the Board on 26th June 2025 and signed on behalf of the Board by:

Chief Executive: Jason Killens

Date: 26 June 2025.

The notes on pages 6 to 76 form part of these accounts.

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

2024-25	Public Dividend Capital £000	Retained earnings £000	Revaluation reserve £000	Total £000
Changes in taxpayers' equity for 2024-25				
Balance as at 31 March 2024	79,701	(3,366)	13,100	89,435
NHS Wales Transfer	0	0		0
RoU Asset Transitioning Adjustment	0	0	0	0
Impact of IFRS 16 on PPP/PFI Liability	0	0	0	0
Balance at 1 April 2024	79,701	(3,366)	13,100	89,435
Retained surplus/(deficit) for the year		70		70
Net gain/(loss) on revaluation of property, plant and equipment		0	243	243
Net gain/(loss) on revaluation of right of use assets		0	0	0
Net gain/(loss) on revaluation of intangible assets		0	0	0
Net gain/(loss) on revaluation of financial assets		0	0	0
Net gain/(loss) on revaluation of assets held for sale		0	0	0
Net gain/(loss) on revaluation of financial assets held for sale		0	0	0
Impairments and reversals		0	(436)	(436)
Other reserve movement		2	147	149
Transfers between reserves		0	0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0	0
Reserves eliminated on dissolution	0			0
Total in year movement	0	72	(46)	26
New Public Dividend Capital received	5,199			5,199
Public Dividend Capital repaid in year	(4,557)			(4,557)
Public Dividend Capital extinguished/written off	0			0
PDC Cash Due but not issued	0			0
Other movements in PDC in year	0			0
Balance at 31 March 2025	80,343	(3,294)	13,054	90,103

The notes on pages 6 to 76 form part of these accounts.

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

2023-24	Public Dividend Capital £000	Retained earnings £000	Revaluation reserve £000	Total £000
Changes in taxpayers' equity for 2023-24				
Balance at 31 March 2023	80,922	(4,007)	13,011	89,926
NHS Wales Transfer	0	0	0	0
RoU Asset Transitioning Adjustment	0	0	0	0
Balance at 1 April 2023	80,922	(4,007)	13,011	89,926
Retained surplus/(deficit) for the year		85		85
Net gain/(loss) on revaluation of property, plant and equipment		0	996	996
Net gain/(loss) on revaluation of right of use assets		0	0	0
Net gain/(loss) on revaluation of intangible assets		0	0	0
Net gain/(loss) on revaluation of financial assets		0	0	0
Net gain/(loss) on revaluation of assets held for sale		0	0	0
Net gain/(loss) on revaluation of financial assets held for sale		0	0	0
Impairments and reversals		0	(333)	(333)
Other reserve movement		(18)	0	(18)
Transfers between reserves		574	(574)	0
Reclassification adjustment on disposal of available for sale financial assets		0	0	0
Reserves eliminated on dissolution	0			0
Total in year movement	0	641	89	730
New Public Dividend Capital received	16,881			16,881
Public Dividend Capital repaid in year	(18,102)			(18,102)
Public Dividend Capital extinguished/written off	0			0
PDC Cash Due but not issued	0			0
Other movements in PDC in year	0			0
Balance at 31 March 2024	79,701	(3,366)	13,100	89,435

The notes on pages 6 to 76 form part of these accounts.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2025

		2024-25	2023-24
	Note	£000	£000
Operating surplus/(deficit)	SOCI	(1,365)	(1,208)
Movements in working capital	30	58	(5,691)
Other cash flow adjustments	31	22,436	27,306
Provisions utilised		(2,432)	(2,097)
Interest paid		(173)	(272)
Net cash inflow (outflow) from operating activities		18,524	18,038
Cash flows from investing activities			
Interest received		1,400	1,253
(Payments) for property, plant and equipment		(22,779)	(17,457)
Proceeds from disposal of property, plant and equipment		375	432
(Payments) for intangible assets		(3,836)	(103)
Proceeds from disposal of intangible assets		0	0
Payments for investments with Welsh Government		0	0
Proceeds from disposals with Welsh Government		0	0
(Payments) for financial assets.		0	0
Proceeds from disposal of financial assets.		0	0
Net cash inflow (outflow) from investing activities		(24,840)	(15,875)
Net cash inflow (outflow) before financing		(6,316)	2,163
Cash flows from financing activities			
Public Dividend Capital received		5,199	16,881
Public Dividend Capital repaid		(4,557)	(18,102)
Loans received from Welsh Government		0	0
Loans repaid to Welsh Government		0	0
Other loans received		0	0
Other loans repaid		0	0
Other capital receipts		0	0
Capital elements of finance leases and on-SOFP PFI		0	0
Capital element of payments in respect of on-SoFP PFI		0	0
Capital element of payments in respect of Right of Use Assets		(3,375)	(3,716)
Cash transferred (to)/from other NHS Wales bodies		0	667
Net cash inflow (outflow) from financing activities		(2,733)	(4,270)
Net increase (decrease) in cash and cash equivalents		(9,049)	(2,107)
Cash [and] cash equivalents	19	17,085	19,192
at the beginning of the financial year			
Cash [and] cash equivalents	19	8,036	17,085
at the end of the financial year			

The notes on pages 6 to 76 form part of these accounts.

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of NHS Trusts (NHST) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2024-25 Manual for Accounts. The accounting policies contained in that manual follow the 2024-25 Financial Reporting Manual (FReM), in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the NHST Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the NHST for the purpose of giving a true and fair view has been selected. The particular policies adopted by the NHST are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

From 2018-2019, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FReM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income is received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.

Only non-NHS income may be deferred.

1.4 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency) from 6.3% to 9.4%.

However, NHS Wales organisations are required to account for **their staff** employer contributions of 23.78% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see Other Note within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time Welsh Ambulance Services University NHS Trust commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in Welsh Ambulance Services University NHS Trust's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, Welsh Ambulance Services University NHS Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control;

or

- items form part of the initial equipping and setting-up cost of a new building, vehicle or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. Welsh Ambulance Services NHS Trust has applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2022-23 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Income (SoCI).

From 2015-2016, IFRS 13 Fair Value Measurement must be complied with in full. However IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on Welsh Ambulance Services University NHS Trust or the asset which would prevent access to the market at the reporting date. If Welsh Ambulance Services University NHS Trust could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCI. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This ensures that asset carrying values are not materially overstated.

For All Wales Capital Schemes that are completed in a financial year, NHS Wales organisations are required to obtain a revaluation during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs identified are then charged to operating expenses.

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to Welsh Ambulance Services University NHS Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to use the intangible asset
- how the intangible asset will generate probable future economic benefits
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCI. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCI. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings. Right of use (ROU) asset impairments are reflected in ROU liability.

1.9 Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits therefrom can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCI on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCI. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 leases is effective across public sector from 1 April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These are as follows: The entity has applied the practical expedient offered in the standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 leases and IFRIC 4 determining whether an arrangement contains a lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application, the NHS Trust has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the standard.

The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application has been employed per paragraph C10 (c) of IFRS 16.

Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

List any other transition expedients employed by the entity at its discretion.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16.

There are further expedients or election that have been employed by Welsh Ambulance Services University NHS Trust in applying IFRS 16.

These include:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16

Welsh Ambulance Services University NHS Trust will not apply IFRS 16 to any new leases of intangible assets applying the treatment described in section 1.14 instead.

The NHS Trust is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16, the NHS Trust has assessed that in all other respects these arrangements meet the definition of a lease under the standard.

The NHS Trust is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.11.1 Welsh Ambulance Services University NHS Trust (the entity) as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The NHS Trust employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset the entity applies a revised rate to the remaining lease liability.

Where existing leases are modified, the NHS Trust must determine whether the arrangement constitutes a separate lease and apply the standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the NHS Trust.

1.11.2 Welsh Ambulance Services University NHS Trust (the entity) as lessor (where relevant)

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the NHS Trust net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Where the NHS Trust is an intermediate lessor, being a lessor and a lessee regarding the same underlying asset, classification of the sublease is required to be made by the intermediate lessor considering the term of the arrangement and the nature of the right of use asset arising from the head lease.

On transition, the NHS Trust has reassessed the classification of all of its continuing subleasing arrangements to include peppercorn leases.

1.12 Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14 Provisions

Provisions are recognised when the NHS Trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the NHS Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the NHS Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1 Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operate a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participating NHS Wales bodies. The risk sharing option was implemented in both 2024-25 and 2023-24. The WRPS is hosted by Velindre NHS University Trust.

1.14.2 Future Liability Scheme (FLS)

General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GP services in Wales.

In March 2019, the Minister issued a Direction to Velindre University NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1 April 2019.

1.15 Financial Instruments

From 2018-2019 IFRS 9 Financial Instruments is applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by the NHS Trust is a change to the calculation basis for bad debt provisions: changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

1.16 Financial assets

Financial assets are recognised on the SoFP when the NHS Wales organisation becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses.

All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

1.16.1 Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets 'at fair value' through SoCI; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2 Financial assets at fair value through SoCI

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCI. They are held at fair value, with any resultant gain or loss recognised in the SoCI. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4 Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCI on de-recognition.

1.16.5 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the NHS Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the expenditure and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.16.6 Other financial assets

Listed investments are stated at market value. Unlisted investments are included at cost as an approximation to market value. Quoted stocks are included in the balance sheet at mid-market price, and where holdings are subject to bid / offer pricing their valuations are shown on a bid price. The shares are not held for trading and accordingly are classified as available for sale. Other financial assets are classified as available for sale investments carried at fair value within the financial statements.

1.17 Financial liabilities

Financial liabilities are recognised on the SOFP when the NHS Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired. Loans from Welsh Government are recognised at historical cost.

1.17.1 Financial liabilities are initially recognised at fair value through SoCI

Financial liabilities are classified as either financial liabilities at fair value through the SoCI or other financial liabilities.

1.17.2 Financial liabilities at fair value through the SoCI

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCI. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 Value Added Tax (VAT)

Most of the activities of NHS Wales organisations are outside the scope of VAT and, in general, output VAT does not apply and input VAT on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCI. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Trust has no beneficial interest in them. Details of third party assets are given in the Notes to the accounts.

1.21 Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCI on an accruals basis, including losses which would have been made good through insurance cover had the NHS Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The NHS Trust accounts for all losses and special payments gross (including assistance from the WRPS).

The NHS Trust accrues or provides for the best estimate of future payouts for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5-50%, the liability is disclosed as a contingent liability.

1.22 Pooled budget

The NHS Wales organisation has not entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in the Pooled budget Note.

The pool budget is hosted by one NHS Wales's organisation. Payments for services provided are accounted for as miscellaneous income. The NHS Wales organisation accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

1.23 Critical Accounting Judgements and key sources of estimation uncertainty

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable through the WRPS.

1.25 Provisions for legal or constructive obligations for clinical negligence, personal injury & defence costs

The NHS Trust provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the WRPS which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the NHS Trust, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement:

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Contingent Liability
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision*
		Contingent Liability for all other estimated expenditure
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

* Defence fee costs are provided for at 25%

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of 0.5%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%-94% respectively are held as a provision on Welsh Ambulance Services University NHS Trust's balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

1.26 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

1.27 Private Finance Initiative (PFI) transactions

The Trust has no PFI arrangements.

1.28 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.29 Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting, dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

For transfers of functions involving NHS Wales Trusts in receipt of PDC the double entry for the fixed asset NBV value and the net movement in assets is PDC.

1.30 Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM:

IFRS14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 17 Insurance Contracts, Application required for accounting periods beginning on or after 1 January 2023, Standard is UK endorsed and adopted by the FReM. *The date of initial application is the beginning of the annual reporting period in which IFRS 17 is first applied. In central government the date of initial application is 1 April 2025.*

IFRS 18 Presentation and Disclosure in Financial Statements - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

1.31 Accounting standards issued that have been adopted early

During 2024-25 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.32 Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as it is the corporate trustee of the Welsh Ambulance Services NHS Trust Charitable Fund it is therefore considered for accounting standards compliance to have control of the Welsh Ambulance Services NHS Trust Charitable Fund as a subsidiary.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Welsh Ambulance Services NHS Trust Charitable Fund or its independence in its management of charitable funds.

However the organisation has with the agreement of the Welsh Government adopted the IAS 27(10) exemption to consolidate. Welsh Government as the ultimate parent of the NHS Wales organisations will disclose the Charitable Accounts in the Welsh Government Consolidated Accounts. Details of the transactions with the charity are included in the related parties notes.

1.33 Subsidiaries

Material entities over which the NHS Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS Trust or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.35 Public Dividend Capital (PDC) and PDC dividend

PDC represents taxpayers' equity in the NHS Trust. At any time the Minister for Health and Social Services with the approval of HM Treasury can issue new PDC to, and require repayments of, PDC from the NHS Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

From 1 April 2010 the requirement to pay a public dividend over to the Welsh Government ceased.

2. Financial Performance

2.1 STATUTORY FINANCIAL DUTIES

Under the National Health Services (Wales) Act 2006 the financial obligations of the NHS Trust are contained within Schedules 4 2(1) and 4(2).

The Trust is required to achieve financial breakeven over a rolling 3 year period.

Welsh Health Circular WHC/2016/054 replaced WHC/2015/014 ‘Statutory and Financial Duties of Local Health Boards and NHS Trusts’ and further clarifies the statutory financial duties of NHS Wales bodies.

2.1.1 Financial Duty

	Annual financial performance			2022-23 to 2024-25 Financial duty £000
	2022-23 £000	2023-24 £000	2024-25 £000	
Retained surplus	62	85	70	217
Less Donated asset / grant funded revenue adjustment	0	0	0	0
Adjusted surplus/ (Deficit)	62	85	70	217

The Welsh Ambulance Services University NHS Trust has met its financial duty to break even over the 3 years 2022-23 to 2024-2025.

2.1.2 Integrated Medium Term Plan (IMTP)

The NHS Wales Planning Framework for the period 2024-2027 issued to Trusts placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The Trust submitted an Integrated Medium Term Plan for the period 2024-2027 in accordance with NHS Wales Planning Framework.

The Minister for Health and Social Services approval status.

Status	Approved
Date	09/08/2024

The Welsh Ambulance Services University NHS Trust has therefore met its statutory duty to have an approved financial plan.

2. Financial Performance (cont)

2.2 ADMINISTRATIVE REQUIREMENTS

2.2.1. External financing

The EFL target has been suspended for 2024-25, on the basis of value for money and the impracticality in relation to the length of deposit time required by the NLF to accept deposits.

2.3. Creditor payment

The Trust is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The Trust has achieved the following results:

	2024-25	2023-24
Total number of non-NHS bills paid	53,595	50,454
Total number of non-NHS bills paid within target	52,380	48,650
Percentage of non-NHS bills paid within target	97.7%	96.4%
The Trust has met the target.		

3. Revenue from patient care activities

	2024-25	2023-24
	£000	£000
Local health boards	5,966	16,576
NWJCC/WHSSC and EASC	275,426	243,560
Welsh NHS Trusts	899	891
Welsh Special Health Authorities	0	0
Foundation Trusts	0	0
Other NHS England bodies	97	152
Other NHS Bodies	0	0
Local Authorities	1	0
Welsh Government	31,546	30,238
Welsh Government - Hosted Bodies	0	0
Non NHS:		
Private patient income	0	0
Overseas patients (non-reciprocal)	0	0
Injury Costs Recovery (ICR) Scheme	183	89
Other revenue from activities	244	529
Total	314,362	292,035

Injury Cost Recovery (ICR) Scheme income:

	2024-25	2023-24
	%	%
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	24.45	23.07

4. Other operating revenue

	2024-25	2023-24
	£000	£000
Income generation	0	0
Patient transport services	0	0
Education, training and research	2,000	1,770
Charitable and other contributions to expenditure	0	0
Receipt of Covid Items free of charge from other NHS Wales Organisations	0	0
Receipt of Covid Items free of charge from other organisations	0	0
Receipt of donations for capital acquisitions	0	0
Receipt of government grants for capital acquisitions	0	0
Right of Use Grant (Peppercorn Lease)	0	0
Non-patient care services to other bodies	0	0
Right of Use Asset Sub-leasing rental income	0	0
Rental revenue from finance leases	0	0
Rental revenue from operating leases	336	205
Other revenue:		
Provision of pathology/microbiology services	0	0
Accommodation and catering charges	0	0
Mortuary fees	0	0
Staff payments for use of cars	67	61
Business unit	0	0
Scheme Pays Reimbursement Notional	0	0
Other	6,826	11,079
Total	9,229	13,115
Total Patient Care and Operating Revenue	323,591	305,150

Other revenue comprises:

Personal injury benefit scheme (PIBS)	738	202
Hazardous Area Response Team (HART)	2,773	2,664
Other minor services income	1,597	1,403
Funding for impairments (as funds flow monies)	1,718	6,810

Total	6,826	11,079

5. Operating expenses	2024-25	2023-24
5.1 Operating expenses	£000	£000
Local Health Boards	142	108
Welsh NHS Trusts	1,068	1,014
Welsh Special Health Authorities	0	0
Goods and services from other NHS bodies	0	0
NWJCC/ WHSSC and EASC	0	0
Local Authorities	0	0
Purchase of healthcare from non-NHS bodies	13,012	11,693
Welsh Government	612	511
Other NHS Trusts	0	0
Directors' costs	1,984	1,804
Operational Staff costs	234,153	216,799
Single lead employer Staff Trainee Cost	0	0
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	5,383	5,709
Supplies and services - general	3,014	2,219
Consultancy Services	584	496
Establishment	5,328	4,638
Transport	17,179	17,369
Premises	16,691	14,005
Impairments and Reversals of Receivables	0	0
Depreciation	14,854	13,896
Depreciation (RoU Asset)	3,409	3,738
Amortisation	1,137	669
Impairments and reversals of property, plant and equipment	1,653	3,847
Fixed asset impairments and reversals (RoU Assets)	0	0
Impairments and reversals of intangible assets	65	2,808
Impairments and reversals of financial assets	0	0
Impairments and reversals of non current assets held for sale	0	0
Audit fees	202	210
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	1,665	(367)
Research and development	0	0
Expense related to short-term leases	101	0
Expense related to low-value asset leases (excluding short-term leases)	0	0
Other operating expenses	2,720	5,192
Total	324,956	306,358

5. Operating expenses (continued)

5.2 Losses, special payments and irrecoverable debts:

Charges to operating expenses	2024-25	2023-24
Increase/(decrease) in provision for future payments:	£000	£000
Clinical negligence;-		
Secondary care	(36)	1,876
Primary care	0	0
Redress Secondary Care	0	(39)
Redress Primary Care	0	0
Personal injury	767	51
All other losses and special payments	485	0
Defence legal fees and other administrative costs	64	97
Structured Settlements Welsh Risk Pool	0	0
Gross increase/(decrease) in provision for future payments	1,280	1,985
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	60	(58)
Less: income received/ due from Welsh Risk Pool	325	(2,294)
Total charge	1,665	(367)

Personal injury includes £0.727m in respect of permanent injury benefits.

The contribution to the Welsh Risk Pool risk share is disclosed within Note 5.1.

	2024-25	2023-24
	£	£
Permanent injury included within personal injury:	727,208	202,233

6. Investment revenue	2024-25	2023-24
Rental revenue :	£000	£000
PFI finance lease revenue:		
Planned	0	0
Contingent	0	0
Other finance lease revenue	0	0
Interest revenue:		
Bank accounts	1,400	1,253
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Total	1,400	1,253

7. Other gains and losses	2024-25	2023-24
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	0	0
Gain/(loss) on disposal other than by sale of right of use assets	0	0
Gain/(loss) on disposal of intangible assets	0	0
Gain/(loss) on disposal of assets held for sale	375	432
Gain/(loss) on disposal of financial assets	0	0
Gains/(loss) on foreign exchange	0	0
Change in fair value of financial assets at fair value through income statement	0	0
Change in fair value of financial liabilities at fair value through income statement	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	375	432

8. Finance costs	2024-25	2023-24
	£000	£000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under Right of Use Leases	173	272
Interest on obligations under PFI contracts:		
Main finance cost	0	0
Contingent finance cost	0	0
Impact of IFRS 16 on PPP/PFI contracts	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	173	272
Provisions unwinding of discount	167	120
Periodical Payment Order unwinding of discount	0	0
Other finance costs	0	0
Total	340	392

9. Future change to SoCI/Operating Leases

9.1 Trust as lessee

Operating lease payments represent rentals payable by Welsh Ambulance Services University NHS Trust for properties and vehicles outside the scope of IFRS 16.

	2024-25 Low Value & Short Term	2024-25 Other	2024-25 Total	2023-24 Total
Payments recognised as an expense				
	£000	£000	£000	£000
Minimum lease payments	101	1,254	1,355	809
Contingent rents	0	0	0	0
Sub-lease payments	0	0	0	0
Total	101	1,254	1,355	809
Total future minimum lease payments				
	2024-25 £000	2024-25 £000	2024-25 £000	2023-24 £000
Payable:				
Not later than one year	11	842	853	666
Between one and five years	0	1,233	1,233	1,222
After 5 years	0	284	284	430
Total	11	2,359	2,370	2,318
Total future sublease payments expected to be received	0	0	0	0

9. Future change to SoCI/Operating Leases (continued)

9.2 Trust as lessor

The Trust leases part of Vantage Point House to Aneurin Bevan NHS Trust in respect of their GP Out of Hours service.

Rental Revenue

Receipts recognised as income	2024-25 £000	2023-24 £000
Rent	0	0
Contingent rent	0	0
Other	244	207
Total rental revenue	244	207

Total future minimum lease payments	2024-25	2023-24
Receivable:	£000	£000
Not later than one year	244	0
Between one and five years	0	0
After 5 years	1	1
Total	245	1

10. Employee costs and numbers

						2024-25	2023-24
10.1 Employee costs	Permanently	Staff on	Agency	Specialist	Other	£000	£000
Operational Staff	employed	Inward	Staff	Trainee	Staff		
	staff	Secondment		(SLE)			
	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	179,935	164	1,407	0	0	181,506	171,446
Social security costs	17,852	0	0	0	0	17,852	17,071
Employer contributions to NHS Pensions Scheme	36,878	0	0	0	0	36,878	30,193
Other pension costs	108	0	0	0	0	108	10
Other post-employment benefits	0	0	0	0	0	0	0
Termination benefits	164	0	0	0	0	164	54
Total	234,937	164	1,407	0	0	236,508	218,774

Of the total above:

Charged to capital	336	297
Charged to revenue	236,172	218,477
Total	236,508	218,774

Net movement in accrued employee benefits (untaken staff leave) 82 223

10.2 Average number of employees

	Permanently	Staff on	Agency	Specialist	Other	2024-25	2023-24
	Employed	Inward	Staff	Trainee	Staff	Total	Total
		Secondment		(SLE)			
	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	673	7	10	0	0	690	643
Medical and dental	1	0	0	0	0	1	0
Nursing, midwifery registered	196	0	0	0	0	196	191
Professional, scientific and technical staff	3	0	0	0	0	3	3
Additional Clinical Services	1,972	0	2	0	0	1,974	2,071
Allied Health Professions	1,161	0	1	0	0	1,162	1,103
Healthcare scientists	0	0	0	0	0	0	0
Estates and Ancillary	59	0	6	0	0	65	68
Students	0	0	0	0	0	0	0
Total	4,065	7	19	0	0	4,091	4,079

10.3. Retirements due to ill-health

	2024-25	2023-24
Number	3	11
Estimated additional pension costs £	289,507	806,212

The estimated additional pension costs of these ill-health retirements have been calculated on an average basis and are borne by the NHS Pension Scheme.

10.4 Employee benefits

Employee benefits refer to non-pay benefits which are not attributable to individual employees, for example group membership of a club. The trust does not operate any employee benefit schemes.

10.5 Reporting of other compensation schemes - exit packages

10.5.1 Exit Packages Costs and Numbers

	2024-25	2024-25	2024-25	2024-25	2023-24
Exit packages cost band (including any special payment element)	Number of compulsory redundancies Whole numbers only	Number of other departures Whole numbers only	Total number of exit packages Whole numbers only	Number of departures where special payments have been made Whole numbers only	Total number of exit packages Whole numbers only
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	3	3	3	0
£25,000 to £50,000	0	1	1	1	0
£50,000 to £100,000	0	1	1	0	1
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	5	5	4	1

	2024-25	2024-25	2024-25	2024-25	2023-24
Exit packages cost band (including any special payment element)	Cost of compulsory redundancies £	Cost of other departures £	Total cost of exit packages £	Cost of special element included in exit packages £	Total cost of exit packages £
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	55,000	55,000	55,000	0
£25,000 to £50,000	0	30,000	30,000	30,000	0
£50,000 to £100,000	0	79,365	79,365	0	53,678
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	164,365	164,365	85,000	53,678

Total Exit Costs Paid in Year	Total paid in year 2024-25 £	Total paid in year 2023-24 £
Exit costs paid in year	53,648	53,776
Total	53,648	53,776

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS).

Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

10.5 Reporting of other compensation schemes - exit packages continued

10.5.2 Analysis of other departures

	2024-25	2024-25
	Agreements	Total value of
Type of other departures	Number	agreements
		£
Voluntary redundancies including early retirement contractual costs	1	79365
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring Welsh Government Approval**	4	85000
Other please specify	0	0
Other please specify	0	0
Total	5	164365

This disclosure provides detail for the number and value of exit packages agreed in the year.

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.5.1 which will be the number of individuals.

**The amounts shown above includes one non-contractual severance payment of £20,000 made following judicial mediation, and three amounts (£15,000, £20,000 and £30,000) relating to non-contractual payments in lieu of notice.

10.6 Fair Pay disclosures

10.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director /employee in

	2024-25 £	2024-25 £	2024-25 Ratio	2023-24 £	2023-24 £	2023-24 Ratio
	Chief Executive			Chief Executive		
Total pay and benefits	187,500	30,420	6.16:1	172,500	28,906	5.97:1
25th percentile pay ratio	187,500	30,420	6.16:1	172,500	28,906	5.97:1
Median pay	187,500	38,999	4.81:1	172,500	36,067	4.78:1
75th percentile pay ratio	187,500	53,416	3.51:1	172,500	48,629	3.55:1
Salary component of total pay and benefits						
25th percentile pay ratio	187,500	26,060		177,500	24,701	
Median pay	187,500	30,420		177,500	28,010	
75th percentile pay ratio	187,500	45,637		177,500	43,257	
	Highest Paid Director			Highest Paid Director		
Total pay and benefits	187,500	30,420	6.16:1	172,500	28,906	5.97:1
25th percentile pay ratio	187,500	30,420	6.16:1	172,500	28,906	5.97:1
Median pay	187,500	38,999	4.81:1	172,500	36,067	4.78:1
75th percentile pay ratio	187,500	53,416	3.51:1	172,500	48,629	3.55:1
Salary component of total pay and benefits						
25th percentile pay ratio	187,500	26,060		177,500	24,701	
Median pay	187,500	30,420		177,500	28,010	
75th percentile pay ratio	187,500	45,637		177,500	43,257	

In 2024-25, 0 (2023-24, 0) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £23,970 to £187,500 (2023-24, £22,720 to £177,500).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

In terms of these disclosures, the Chief Executive is also the highest paid director.

Financial year summary

In keeping with the Welsh Government circulars on pay, included in the calculations for 2024/25 are the 5.5% pay increase for employees covered by Agenda for Change (AfC) and the 5.0% pay increase for employees covered by Executive and Senior Posts (ESP).

Prior year figures have not been adjusted to take account of the revised Manual for Accounts, this has been applied for 2024-25 only, therefore salary sacrifice schemes are still currently deducted from the 2023-24 figures included under total pay and benefits.

10.6.2 Percentage Changes

	2023-24 to 2024-25 %	2022-23 to 2023-24 %
% Change from previous financial year in respect of Chief Executive		
Salary and allowances	8.7	3
Performance pay and bonuses	0.0	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	8.7	3
Performance pay and bonuses	0.0	0
Average % Change from previous financial year in respect of employees taken as a whole		
Salary and allowances	7.8	5
Performance pay and bonuses	0.0	0

Prior year figures have not been adjusted to take account of the revised Manual for Accounts, this has been applied for 2024-25 only.

The 3.0% reported in 2023/24 is in relation to the pay award received in 2023/24, based on the mid-point of the band.

The 8.7% reported in 2024/25 is in relation to the pay award received in 2024/25 based on the mid-point of the band, and the exclusion of salary sacrifice schemes as per the new guidance.

If the prior year had been adjusted, the % change from previous financial year in respect for Chief Executive and the highest paid director would be 5.6%, based on the mid-point of the band.

The 5.0% in 2023/24 in terms of the average pay per FTE was related to the pay award received and accrued for during 2023/24. The 7.8% reported in 2024/25 relates to the agreed pay increases across the organisation, with salary sacrifice schemes excluded.

If the prior year had been adjusted, the average % change from previous financial year in respect of employees taken as a whole would be 6.1%.

11. Pensions

PENSION COSTS

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2024-25 tax year (2023-24 £6,240 and £50,270).

Restrictions on the annual contribution limits were removed on 1st April 2017.

12. Public Sector Payment Policy

12.1 Prompt payment code - measure of compliance

The Welsh Government requires that trusts pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the trust financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery or receipt of a valid invoice, whichever is the later.

	2024-25 Number	2024-25 £000	2023-24 Number	2023-24 £000
NHS				
Total bills paid in year	1,580	13,122	1,343	16,672
Total bills paid within target	1,547	12,774	1,274	15,183
Percentage of bills paid within target	97.9%	97.3%	94.9%	91.1%
Non-NHS				
Total bills paid in year	53,595	142,878	50,454	134,242
Total bills paid within target	52,380	141,256	48,650	132,277
Percentage of bills paid within target	97.7%	98.9%	96.4%	98.5%
Total				
Total bills paid in year	55,175	156,000	51,797	150,914
Total bills paid within target	53,927	154,030	49,924	147,460
Percentage of bills paid within target	97.7%	98.7%	96.4%	97.7%

12.2 The Late Payment of Commercial Debts (Interest) Act 1998	2024-25	2023-24
	£	£
Amounts included within finance costs from claims made under legislation	0	0
Compensation paid to cover debt recovery costs under legislation	0	0
Total	0	0

13. Property, plant and equipment :

2024-25

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport Equipment	Information Technology	Furniture and fittings	Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost at 31 March bf	9,199	34,020	0	14,430	20,827	85,505	17,550	1,444	182,975
Classification correction	(18)	(3,432)	0	(104)	(9)	0	0	(347)	(3,910)
At 1 April 2024	9,181	30,588	0	14,326	20,818	85,505	17,550	1,097	179,065
Indexation	98	175	0	0	0	0	0	0	273
Additions - purchased	0	2,723	0	16,343	25	1,005	567	0	20,663
Additions - donated	0	0	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	338	0	(12,268)	853	8,913	2,143	175	154
Revaluation	(5)	(284)	0	0	0	0	0	0	(289)
Reversal of impairments	0	354	0	0	0	0	0	0	354
Impairments	(149)	(2,003)	0	(10)	0	0	(17)	0	(2,179)
Reclassified as held for sale	0	0	0	0	(1,276)	(7,139)	0	0	(8,415)
Disposals other than by sale	0	0	0	0	(1,543)	(363)	(4,982)	(247)	(7,135)
At 31 March 2025	9,125	31,891	0	18,391	18,877	87,921	15,261	1,025	182,491

Depreciation

Depreciation at 31 March bf	18	6,311	0	104	14,662	54,229	10,289	1,255	86,868
Classification correction	(18)	(3,432)	0	(104)	(9)	0	0	(347)	(3,910)
At 1 April 2024	0	2,879	0	0	14,653	54,229	10,289	908	82,958
Indexation	0	30	0	0	0	0	0	0	30
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	1	0	0	(2)	0	0	0	(1)
Revaluation	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	(172)	0	0	0	0	0	0	(172)
Reclassified as held for sale	0	0	0	0	(1,276)	(7,139)	0	0	(8,415)
Disposals other than by sale	0	0	0	0	(1,543)	(363)	(4,982)	(247)	(7,135)
Charged during the year	0	963	0	0	1,647	9,763	2,362	119	14,854
At 31 March 2025	0	3,701	0	0	13,479	56,490	7,669	780	82,119

Net book value

At 1 April 2024	9,181	27,709	0	14,326	6,165	31,276	7,261	189	96,107
Net book value									
At 31 March 2025	9,125	28,190	0	18,391	5,398	31,431	7,592	245	100,372

Net book value at 31 March 2025 comprises :

Purchased	9,125	28,190	0	18,391	5,387	31,357	7,592	245	100,287
Donated	0	0	0	0	11	74	0	0	85
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2025	9,125	28,190	0	18,391	5,398	31,431	7,592	245	100,372

Asset Financing:

Owned	9,125	28,190	0	18,391	5,398	31,431	7,592	245	100,372
On-SoFP MIMS Funded PPP contracts	0	0	0	0	0	0	0	0	0
On-SoFP PFI contract	0	0	0	0	0	0	0	0	0
PFI residual interest	0	0	0	0	0	0	0	0	0
At 31 March 2025	9,125	28,190	0	18,391	5,398	31,431	7,592	245	100,372

The net book value of land, buildings and dwellings at 31 March 2025 comprises :

	£000
Freehold	35,065
Long Leasehold	2,250
Short Leasehold	0
Total	37,315

Valuers 'material uncertainty', in valuation.

0

The disclosure relates to the materiality in the valuation report not that of the underlying account.

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. The Trust is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

Classification corrections have been made to the opening cost and accumulated depreciation, in order to comply with the updated Manual for Accounts and to ensure the 2023/24 audited Annual Accounts fully agree to the Trusts Fixed Asset Register for the classification of impairments between cost and accumulated depreciation. The closing Net Book Values disclosed within the 2023/24 audited accounts agreed to the Trusts Fixed Asset Register. The differences identified related to accumulated cost and accumulated depreciation only and did not impact on the overall Net Book Values disclosed.

13. Property, plant and equipment :

2023-24

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport Equipment	Information Technology	Furniture and fittings	Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost at 31 March bf	9,255	26,670	0	25,491	18,671	79,152	17,887	1,446	178,572
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	0
At 1 April 2023	9,255	26,670	0	25,491	18,671	79,152	17,887	1,446	178,572
Indexation	(268)	1,315	0	0	0	0	0	0	1,047
Additions - purchased	0	1,342	0	15,688	547	710	99	(2)	18,384
Additions - donated	0	0	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	(188)	(540)	0	0	0	0	0	0	(728)
Reclassifications	400	5,657	0	(26,749)	2,718	11,202	3,627	0	(3,145)
Revaluation	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	(335)	0	0	0	0	0	0	(335)
Reclassified as held for sale	0	0	0	0	(934)	(5,557)	0	0	(6,491)
Disposals other than by sale	0	(89)	0	0	(175)	(2)	(4,063)	0	(4,329)
At 31 March 2024	9,199	34,020	0	14,430	20,827	85,505	17,550	1,444	182,975
Depreciation									
Depreciation at 31 March bf	0	2,037	0	0	14,180	51,214	11,720	804	79,955
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	0
At 1 April 2023	0	2,037	0	0	14,180	51,214	11,720	804	79,955
Indexation	0	51	0	0	0	0	0	0	51
Transfers from/(into) other NHS bodies	0	(61)	0	0	0	0	0	0	(61)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	(173)	0	0	0	0	0	0	(173)
Impairments	18	3,597	0	104	9	0	0	292	4,020
Reclassified as held for sale	0	0	0	0	(934)	(5,557)	0	0	(6,491)
Disposals other than by sale	0	(89)	0	0	(175)	(2)	(4,063)	0	(4,329)
Charged during the year	0	949	0	0	1,582	8,574	2,632	159	13,896
At 31 March 2024	18	6,311	0	104	14,662	54,229	10,289	1,255	86,868
Net book value									
At 1 April 2023	9,255	24,633	0	25,491	4,491	27,938	6,167	642	98,617
Net book value									
At 31 March 2024	9,181	27,709	0	14,326	6,165	31,276	7,261	189	96,107
Net book value at 31 March 2024 comprises :									
Purchased	9,181	27,709	0	14,326	6,151	31,175	7,261	189	95,992
Donated	0	0	0	0	14	101	0	0	115
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2024	9,181	27,709	0	14,326	6,165	31,276	7,261	189	96,107
Asset Financing:									
Owned	9,181	27,709	0	14,326	6,165	31,276	7,261	189	96,107
On-SoFP MIMS Funded PPP contracts	0	0	0	0	0	0	0	0	0
On-SoFP PFI contract	0	0	0	0	0	0	0	0	0
PFI residual interest	0	0	0	0	0	0	0	0	0
At 31 March 2024	9,181	27,709	0	14,326	6,165	31,276	7,261	189	96,107

The net book value of land, buildings and dwellings at 31 March 2024 comprises :

	£000
Freehold	35,107
Long Leasehold	1,783
Short Leasehold	0
Total	36,890

Valuers 'material uncertainty', in valuation.

0

The disclosure relates to the materiality in the valuation report not that of the underlying account.

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. The Trust is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

13. Property, plant and equipment :

Disclosures:

i) Donated Assets

The Welsh Ambulance Service University NHS Trust has not received any donated assets during the year.

ii) Valuations

The NHS Trust land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

A Chartered Surveyor was used during the 2024/25 financial year to value an asset that became operational during the year.

The NHS Trust is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

iii) Asset Lives

Depreciated on a straight line basis over their useful lives as follows:

- Land is not depreciated.
- Assets under construction are not depreciated.
- Buildings useful lives are determined by the Valuation Office Agency.
- Equipment lives range from 3.5 - 9 years.

iv) Compensation

£1.718m was received from Welsh Government in respect of compensation for assets impaired during the year. This includes £1.152m in respect of a building that was brought into use in March 2025. The compensation received is included within the income statement.

v) Write Downs

There has been accelerated depreciation of £0.122m during the year.

vi) The NHS Trust does not hold any property where the value is materially different from its open market value.

vii) Assets Held for Sale or sold in the period

Assets transferred to held for sale during the year are shown in Note 13. The Net Book Value of assets held for sale are shown in Note 13.2. Assets sold within the financial year are detailed below.

viii) IFRS 13 Fair value measurement

There are no assets requiring Fair Value measurement under IFRS 13.

13.2 Non-current assets held for sale

	Land	Buildings, including dwellings	Other property plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance b/f 1 April 2024	0	0	0	0	0	0
Plus assets classified as held for sale in year	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Less assets sold in year	0	0	0	0	0	0
Plus reversal of impairments	0	0	0	0	0	0
Less impairment for assets held for sale	0	0	0	0	0	0
Less assets no longer classified as held for sale for reasons other than disposal by sale	0	0	0	0	0	0
Balance c/f 31 March 2025	0	0	0	0	0	0
Balance b/f 1 April 2023	0	0	0	0	0	0
Plus assets classified as held for sale in year	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Less assets sold in year	0	0	0	0	0	0
Plus reversal of impairments	0	0	0	0	0	0
Less impairment for assets held for sale	0	0	0	0	0	0
Less assets no longer classified as held for sale for reasons other than disposal by sale	0	0	0	0	0	0
Balance c/f 31 March 2024	0	0	0	0	0	0

Within Note 13 there is £7.139m of Transport equipment and £1.276m of Plant & Machinery that is reclassified as held for sale during the year. These relate to fully depreciated vehicles and equipment, of which £6.665m have been sold during the year and £1.750m remain within assets held for sale as they did not sell during the year.

Note 7 shows the gain/loss on disposals made during the year.

13.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings within the note. Most are individually insignificant, however, 1 is significant in their own right:

VPH HQ & Control held under land and buildings NBV at 31 March 2025 £2,214k.

	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
2024-25									
Cost or valuation at 1 April 2024	0	12,198	0	0	0	94	25,774	0	38,066
Additions	0	(193)	0	0	0	106	(41)	0	(128)
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	(183)	0	0	0	(70)	0	0	(253)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
At 31 March 2025	0	11,822	0	0	0	130	25,733	0	37,685
Depreciation at 1 April 2024	0	2,767	0	0	0	65	22,867	0	25,699
Recognition	0	0	0	0	0	0	0	0	0
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	(183)	0	0	0	(70)	0	0	(253)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
Provided during the year	0	1,411	0	0	0	39	1,959	0	3,409
At 31 March 2025	0	3,995	0	0	0	34	24,826	0	28,855
Net book value at 1 April 2024	0	9,431	0	0	0	29	2,907	0	12,367
Net book value at 31 March 2025	0	7,827	0	0	0	96	907	0	8,830
RoU Asset Total Value Split by Lessor									
	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	563	0	0	0	0	0	0	563
NHS Wales Market Value Leases	0	397	0	0	0	0	0	0	397
Other Public Sector Peppercorn Leases	0	353	0	0	0	0	0	0	353
Other Public Sector Market Value Leases	0	1,267	0	0	0	0	0	0	1,267
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	0
Private Sector Market Value Leases	0	5,247	0	0	0	96	907	0	6,250
Total	0	7,827	0	0	0	96	907	0	8,830

The Land & Buildings additions shown above consist of 12 leases which are new or have rent increases totalling £0.161m and 2 amendments to leases totalling -£0.354m following a reduction in a rental period and a reduction in square meterage. The IT additions of -£0.041m shown above is in relation to a rental charge adjustment.

13.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most/all are individually insignificant, however, 2 are significant in their own right:
 Vantage Point House Headquarters & Control held under land and buildings Net Book Value at 31 March 2024 £2,530k
 Airwave under information technology nbv at 31 March 2024 £2,907k

	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
2023-24									
Cost or valuation at 31 March 2023	0	12,270	0	0	0	71	22,552	0	34,893
Lease prepayments in relation to RoU Assets	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	0	0	0
Operating Leases Transitioning	0	0	0	0	0	0	0	0	0
Cost or valuation at 1 April 2023	0	12,270	0	0	0	71	22,552	0	34,893
Additions	0	123	0	0	0	25	3,222	0	3,370
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	(195)	0	0	0	(2)	0	0	(197)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
At 31 March 2024	0	12,198	0	0	0	94	25,774	0	38,066
Depreciation at 31 March 2023	0	1,465	0	0	0	32	20,661	0	22,158
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	0	0	0
Operating Leases Transitioning	0	0	0	0	0	0	0	0	0
Depreciation at 1 April 2023	0	1,465	0	0	0	32	20,661	0	22,158
Recognition	0	0	0	0	0	0	0	0	0
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	(195)	0	0	0	(2)	0	0	(197)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
Provided during the year	0	1,497	0	0	0	35	2,206	0	3,738
At 31 March 2024	0	2,767	0	0	0	65	22,867	0	25,699
Net book value at 1 April 2023	0	10,805	0	0	0	39	1,891	0	12,735
Net book value at 31 March 2024	0	9,431	0	0	0	29	2,907	0	12,367
RoU Asset Total Value Split by Lessor									
	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	615	0	0	0	0	0	0	615
NHS Wales Market Value Leases	0	444	0	0	0	0	0	0	444
Other Public Sector Peppercorn Leases	0	395	0	0	0	0	0	0	395
Other Public Sector Market Value Leases	0	1,627	0	0	0	0	0	0	1,627
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	0
Private Sector Market Value Leases	0	6,350	0	0	0	29	2,907	0	9,286
Total	0	9,431	0	0	0	29	2,907	0	12,367

13.3 Right of Use Assets continued

Quantitative disclosures

	2024-25	2024-25	2024-25	2024-25	2023-24
	LAND	BUILDINGS	OTHER	TOTAL	Total
	£000	£000	£000	£000	£000
Maturity analysis					
Contractual undiscounted cash flows relating to lease liabilities					
Less than 1 year	0	1,322	666	1,988	3,610
2-5 years	0	4,298	55	4,353	5,372
> 5 years	0	1,745	0	1,745	2,790
Less finance charges allocated to future periods	0	-286	-10	-296	0
Total	0	7,079	711	7,790	11,772
Lease Liabilities (net of irrecoverable VAT)				£000	£000
Current				1,900	3,448
Non-Current				5,890	7,897
Total				7,790	11,345
Amounts Recognised in Statement of Comprehensive Net Expenditure				£000	£000
Depreciation				3,409	3,738
Impairment				0	0
Variable lease payments not included in lease liabilities - Interest expense				173	272
Sub-leasing income				0	0
Expense related to short-term leases				101	37
Expense related to low-value asset leases (excluding short-term leases)				0	0
Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)				£000	£000
Interest expense				-173	-545
Repayments of principal on leases				-3,375	-3,716
Total				-3,548	-4,261

14. Intangible assets

2024-25	Computer software purchased	Computer software internally developed	Licenses and trade-marks	Patents	Development expenditure internally generated	Assets under Construction	Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 31 March bf	10,115	0	4,001	0	0	5,606	19,722
Classification correction	0	0	0	0	0	(2,808)	(2,808)
At 1 April 2024	10,115	0	4,001	0	0	2,798	16,914
Revaluation		0			0	0	0
Reclassifications	2,135	0	161	0	0	(2,450)	(154)
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	(65)	(65)
Additions							
- purchased	(458)	0	139	0	0	105	(214)
- internally generated	0	0	0	0	0	0	0
- donated	0	0	0	0	0	0	0
- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0
Disposals other than by sale	(2,958)	0	(1,765)	0	0	0	(4,723)
At 31 March 2025	8,834	0	2,536	0	0	388	11,758
Amortisation							
Amortisation at 31 March bf	8,562	0	3,120	0	0	2,808	14,490
Classification correction	0	0	0	0	0	(2,808)	(2,808)
At 1 April 2024	8,562	0	3,120	0	0	0	11,682
Revaluation		0			0	0	0
Reclassifications	(17)	0	17	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Charged during the year	870	0	267	0	0	0	1,137
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0
Disposals other than by sale	(2,958)	0	(1,765)	0	0	0	(4,723)
Accumulated amortisation at 31 March 2025	6,457	0	1,639	0	0	0	8,096
Net book value							
At 1 April 2024	1,553	0	881	0	0	2,798	5,232
Net book value							
At 31 March 2025	2,377	0	897	0	0	388	3,662
Net book value							
Purchased	2,377	0	897	0	0	388	3,662
Donated	0	0	0	0	0	0	0
Government granted	0	0	0	0	0	0	0
Internally Generated	0	0	0	0	0	0	0
At 31 March 2025	2,377	0	897	0	0	388	3,662

Classification corrections have been made to the opening cost and accumulated depreciation, in order to comply with the updated Manual for Accounts and to ensure the 2023/24 audited Annual Accounts fully agree to the Trusts Fixed Asset Register for the classification of impairments between cost and accumulated depreciation. The closing Net Book Values disclosed within the 2023/24 audited accounts agreed to the Trusts Fixed Asset Register. The differences identified related to accumulated cost and accumulated depreciation only and did not impact on the overall Net Book Values disclosed.

14. Intangible assets

2023-24	Computer software purchased	Computer software internally developed	Licenses and trade-marks	Patents	Development expenditure internally generated	Assets under Construction	Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000
At 1 April 2023	10,295	0	3,525	0	0	0	13,820
Revaluation		0			0	0	0
Reclassifications	57	0	585	0	0	2,503	3,145
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions							
- purchased	1,112	0	0	0	0	2,892	4,004
- internally generated	0	0	0	0	0	211	211
- donated	0	0	0	0	0	0	0
- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0
Disposals other than by sale	(1,349)	0	(109)	0	0	0	(1,458)
At 31 March 2024	10,115	0	4,001	0	0	5,606	19,722
Amortisation							
At 1 April 2023	9,421	0	3,050	0	0	0	12,471
Revaluation		0			0	0	0
Reclassifications	(50)	0	50	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	2,808	2,808
Charged during the year	540	0	129	0	0	0	669
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0
Disposals other than by sale	(1,349)	0	(109)	0	0	0	(1,458)
Accumulated amortisation at 31 March 2024	8,562	0	3,120	0	0	2,808	14,490
Net book value							
At 1 April 2023	874	0	475	0	0	0	1,349
Net book value							
At 31 March 2024	1,553	0	881	0	0	2,798	5,232
Net book value							
Purchased	1,553	0	881	0	0	2,733	5,167
Donated	0	0	0	0	0	0	0
Government granted	0	0	0	0	0	0	0
Internally Generated	0	0	0	0	0	65	65
At 31 March 2024	1,553	0	881	0	0	2,798	5,232

14. Intangible assets

Disclosures:

i) Donated Assets

Welsh Ambulance Services University NHS Trust has not received any donated intangible assets during the year.

ii) Recognition

Intangible assets acquired separately are initially recognised at fair value.

iii) Asset Lives

The useful economic life of Intangible non-current assets are assigned on an individual asset basis.

iv) Additions during the period

There have been additions to purchased software and licenses during the period. There were negative additions to Software during the year amounting to -£0.458m, the majority of which relate to a project which included VAT in the capital creditor which was then identified as recoverable.

v) Disposals during the period

The disposals made during the period, as shown within Note 14, relate to nil net book value intangibles that have been identified as no longer in use and have been written off.

vi) Transfers into other NHS Bodies

There were no transfers of intangible assets to other NHS bodies during the year.

15. Impairments

	2024-25	2024-25	2024-25	2024-25	2024-25	2024-25
Impairments in the period arose from:	Property, plant & equipment	Right of Use Assets	Intangible assets	Held for sale assets	Financial Assets	Total Asset Impairment
	£000	£000	£000	£000	£000	£000
Loss or damage from normal operations	0	0	0	0	0	0
Abandonment of assets in the course of construction	0	0	65	0	0	65
Over specification of assets (Gold Plating)	0	0	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Changes in market price	1,157	0	0	0	0	1,157
Other	1,286	0	0	0	0	1,286
Reversal of impairment	(354)	0	0	0	0	(354)
Total of all impairments	2,089	0	65	0	0	2,154

Analysis of impairments :

Impairments charged to the Statement of Comprehensive Net Expenditure	1,653	0	0	0	0	1,653
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	436	0	0	0	0	436
Impairments as a result of a loss of economic value or service potential charged to Statement of Comprehensive Net Expenditure	0	0	65	0	0	65
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	2,089	0	65	0	0	2,154

	2023-24	2023-24	2023-24	2023-24	2023-24	2023-24
Impairments in the period arose from:	Property, plant & equipment	Right of Use Assets	Intangible assets	Held for sale assets	Financial Assets	Total Asset Impairment
	£000	£000	£000	£000	£000	£000
Loss or damage from normal operations	0	0	0	0	0	0
Abandonment of assets in the course of construction	0	0	2,808	0	0	2,808
Over specification of assets (Gold Plating)	0	0	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Changes in market price	2,861	0	0	0	0	2,861
Other	1,159	0	0	0	0	1,159
Reversal of impairment	(173)	0	0	0	0	(173)
Total of all impairments	3,847	0	2,808	0	0	6,655

Analysis of impairments :

Impairments charged to the Statement of Comprehensive Net Expenditure	3,847	0	2,808	0	0	6,655
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	335	0	0	0	0	335
Impairments as a result of a loss of economic value or service potential charged to Statement of Comprehensive Net Expenditure	0	0	0	0	0	0
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	4,182	0	2,808	0	0	6,990

Included within the above total of £2.154m are the following items:-

- £1.157m relates to the capital spend on building works over and above the valuation received once the works to the building were complete. £1.152m of this was charged to operating expenses and £0.005m to the Revaluation Reserve

- £0.065m was impaired relating to an agreed contract termination for an IT project being progressed on behalf of all NHS bodies in Wales, this was charged to operating expenses.

- A review of capital expenditure incurred on Trust buildings, in which the overall individual project capital spend did not exceed £0.5m, identified that a total impairment of £1.138m was required as there were instances where the value of the buildings had not been enhanced. Of this amount, £0.707m was charged to operating expenses and £0.431m charged to the Revaluation Reserve.

- £0.354m of impairments previously charged to operating expenses were reversed following upward indexation of assets.

- £0.148m was charged to operating expenses to correct impairments in the prior year incorrectly charged to the Revaluation Reserve which had insufficient balance.

16. Inventories

16.1 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	131	129
Consumables	1,728	1,738
Energy	0	0
Work in progress	0	0
Other	255	252
Total	2,114	2,119
Of which held at net realisable value:	0	0

16.2 Inventories recognised in expenses

	31 March 2025 £000	31 March 2024 £000
Inventories recognised as an expense in the period	0	0
Write-down of inventories (including losses)	0	0
Reversal of write-downs that reduced the expense	0	0
Total	0	0

17. Trade and other receivables

17.1 Trade and other receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Welsh Government	564	339
NWJCC/WHSSC and EASC	48	47
Welsh Health Boards	1,834	3,674
Welsh NHS Trusts	180	144
Welsh Special Health Authorities	16	131
Non - Welsh Trusts	61	32
Other NHS	29	20
2019-20 Scheme Pays - Welsh Government Reimbursement	0	0
Welsh Risk Pool Claim reimbursement:-		
NHS Wales Secondary Health Sector	5,815	7,270
NHS Wales Primary Sector FLS Reimbursement	0	0
NHS Wales Redress	297	367
Other	0	0
Local Authorities	73	48
Capital receivables- Tangible	0	0
Capital receivables- Intangible	0	0
Other receivables	2,540	3,291
Provision for impairment of trade receivables	(273)	(260)
Pension Prepayments		
NHS Pensions Agency	0	0
NEST	0	0
Other prepayments	3,979	2,172
Accrued income	0	0
Sub-total	15,163	17,275
Non-current		
Welsh Government	0	0
NWJCC/WHSSC and EASC	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Non - Welsh Trusts	0	0
Other NHS	0	0
2019-20 Scheme Pays - Welsh Government Reimbursement	0	0
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	0	0
NHS Wales Primary Sector FLS Reimbursement	0	0
NHS Wales Redress	0	0
Other	0	0
Local Authorities	0	0
Capital receivables- Tangible	0	0
Capital receivables- Intangible	0	0
Other receivables	401	388
Provision for impairment of trade receivables	0	0
Pension Prepayments		
NHS Pensions Agency	0	0
NEST	0	0
Other prepayments	0	0
Accrued income	0	0
Sub-total	401	388
Total trade and other receivables	15,564	17,663

The great majority of trade is with other NHS bodies. As NHS bodies are funded by Welsh Government, no credit scoring of them is considered necessary.

The value of trade receivables that are past their payment date but not impaired is £0.823m (£0.242m in 2023-24).

17.2 Receivables past their due date but not impaired

	31 March 2025 £000	31 March 2024 £000
By up to 3 months	478	242
By 3 to 6 months	346	0
By more than 6 months	0	0
Balance at end of financial year	824	242

17.3 Expected Credit Losses (ECL) Allowance for bad and doubtful debts

	31 March 2025 £000	31 March 2024 £000
Balance at 1 April	(260)	(318)
Transfer to other NHS Wales body	0	0
Provision utilised (Amount written off during the year)	23	0
Provision written back during the year no longer required	0	0
(Increase)/Decrease in provision during year	(36)	58
ECL/Bad debts recovered during year	0	0
Balance at end of financial year	(273)	(260)

17.4 Receivables VAT

	31 March 2025 £000	31 March 2024 £000
Trade receivables	33	22
Other	0	0
Total	33	22

18. Other financial assets

	31 March 2025 £000	31 March 2024 £000
Current		
Shares and equity type investments		
Held to maturity investments at amortised costs	0	0
At fair value through SOCI	0	0
Available for sale at FV	0	0
Deposits	0	0
Loans	0	0
Derivatives	0	0
Other (Specify)		
Right of Use Asset Finance Sublease	0	0
Held to maturity investments at amortised costs	0	0
At fair value through SOCI	0	0
Available for sale at FV	0	0
Total	0	0
RoU Sub-leasing income Recognised in Statement of Comprehensive Net Expenditure	2024-25	2023-24
RoU Sub-leasing income	0	0
Non-Current		
Shares and equity type investments		
Held to maturity investments at amortised costs	0	0
At fair value through SOCI	0	0
Available for sale at FV	0	0
Deposits	0	0
Loans	0	0
Derivatives	0	0
Other (Specify)		
Right of Use Asset Finance Sublease	0	0
Held to maturity investments at amortised costs	0	0
At fair value through SOCI	0	0
Available for sale at FV	0	0
Total	0	0

19. Cash and cash equivalents

	31 March 2025 £000	31 March 2024 £000
Opening Balance	17,085	19,192
Net change in year	(9,049)	(2,107)
Closing Balance	8,036	17,085
Made up of:		
Cash with Government Banking Service (GBS)	7,992	16,950
Cash with Commercial banks	44	135
Cash in hand	0	0
Total cash	8,036	17,085
Current investments	0	0
Cash and cash equivalents as in SoFP	8,036	17,085
Bank overdraft - GBS	0	0
Bank overdraft - Commercial banks	0	0
Cash & cash equivalents as in Statement of Cash Flows	8,036	17,085

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are;

Lease Liabilities (ROUA) £3.375m

Lease Liabilities (short-term and low value leases) £0.101m

The movement relates to cash, no comparative information is required by IAS 7 in 2024-25.

20. Trade and other payables at the SoFP Date	31 March 2025 £000	31 March 2024 £000
Current		
Welsh Government	7	1,344
NWJCC/WHSSC and EASC	319	528
Welsh Health Boards	351	301
Welsh NHS Trusts	463	425
Welsh Special Health Authorities	3	9
Other NHS	0	196
Taxation and social security payable / refunds:		
Refunds of taxation by HMRC	0	0
VAT payable to HMRC	139	0
Other taxes payable to HMRC	2,174	1,940
National Insurance contributions payable to HMRC	2,226	2,173
Non-NHS trade payables - revenue	7,232	7,615
Local Authorities	47	62
Capital payables-Tangible	5,229	7,345
Capital payables- Intangible	102	4,152
Overdraft	0	0
Rentals due under operating leases	0	0
RoU Lease Liability	245	21
Obligations due under finance leases and HP contracts		
Imputed finance lease element of on SoFP PFI contracts	0	0
Impact of IFRS 16 on SoFP PFI contracts	0	0
Pensions: staff	3,100	2,852
Non NHS Accruals	7,675	8,209
Deferred Income:		
Deferred income brought forward	310	233
Deferred income additions	168	229
Transfer to/from current/non current deferred income	0	0
Released to the Income Statement	(302)	(152)
Other liabilities - all other payables	0	0
PFI assets – deferred credits	0	0
PFI - Payments on account	0	0
Sub-total	29,488	37,482

The Trust aims to pay all invoices within the 30 day period directed by the Welsh Government.

In respect of the Pensions figure shown above, £3.083m relates to the NHS Pension scheme (£2.835m 2023/24) and £0.017m to the NEST pension scheme (£0.017m 2023/24).

20. Trade and other payables at the SoFP Date (cont)

	31 March 2025 £000	31 March 2024 £000
Non-current		
Welsh Government	0	0
NWJCC/ WHSSC and EASC	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Other NHS	0	0
Taxation and social security payable / refunds:		
Refunds of taxation by HMRC	0	0
VAT payable to HMRC	0	0
Other taxes payable to HMRC	0	0
National Insurance contributions payable to HMRC	0	0
Non-NHS trade payables - revenue	0	0
Local Authorities	0	0
Capital payables- Tangible	0	0
Capital payables- Intangible	0	0
Overdraft	0	0
Rentals due under operating leases	0	0
RoU Lease Liability	0	0
Obligations due under finance leases and HP contracts		
Imputed finance lease element of on SoFP PFI contracts	0	0
Impact of IFRS 16 on SoFP PFI contracts	0	0
Pensions: staff	0	0
Non NHS Accruals	0	0
Deferred Income:		
Deferred income brought forward	0	0
Deferred income additions	0	0
Transfer to/from current/non current deferred income	0	0
Released to the Income Statement	0	0
Other liabilities - all other payables	0	0
PFI assets –deferred credits	0	0
Payments on account	0	0
Sub-total	<u>0</u>	<u>0</u>
Total	<u>29,488</u>	<u>37,482</u>

20. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled :	31 March 2025 £000	31 March 2024 £000
Between one and two years	0	0
Between two and five years	0	0
In five years or more	0	0
Sub-total	<u>0</u>	<u>0</u>

21. Borrowings	31 March	31 March
Current	2025	2024
	£000	£000
Bank overdraft - Government Banking Service (GBS)	0	0
Bank overdraft - Commercial bank	0	0
Loans from:		
Welsh Government	0	0
Other entities	0	0
PFI liabilities:		
Main liability	0	0
Lifecycle replacement received in advance	0	0
Finance lease liabilities		0
RoU Lease Liability	1,900	3,448
Other	0	0
Total	1,900	3,448
 Non-current		
Bank overdraft - GBS	0	0
Bank overdraft - Commercial bank	0	0
Loans from:		
Welsh Government	0	0
Other entities	0	0
PFI liabilities:		
Main liability	0	0
Lifecycle replacement received in advance	0	0
Finance lease liabilities		0
RoU Lease Liability	5,890	7,897
Other	0	0
Total	5,890	7,897

21.2 Loan advance/strategic assistance funding

	31 March	31 March
	2025	2024
	£000	£000
Amounts falling due:		
In one year or less	0	0
Between one and two years	0	0
Between two and five years	0	0
In five years or more	0	0
Sub-total	0	0
Wholly repayable within five years	0	0
Wholly repayable after five years, not by instalments	0	0
Wholly or partially repayable after five years by instalments	0	0
Sub-total	0	0
Total repayable after five years by instalments	0	0

The Trust has not received a loan advance or strategic funding from the Welsh Government.

22. Other financial liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Financial Guarantees		
At amortised cost	0	0
At fair value through SoCI	0	0
Derivatives at fair value through SoCI	0	0
Other		
At amortised cost	0	0
At fair value through SoCI	0	0
Total	0	0

	31 March 2025 £000	31 March 2024 £000
Non-current		
Financial Guarantees		
At amortised cost	0	0
At fair value through SoCI	0	0
Derivatives at fair value through SoCI	0	0
Other		
At amortised cost	0	0
At fair value through SoCI	0	0
Total	0	0

23. Provisions

2024-25

	At 1 April 2024	Structured settlement cases transferred to Risk Pool	Transfers to creditors	Transfers between current and non current	Transfers (to)/from other NHS body	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2025
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Current										
Clinical negligence:-										
Secondary Care	2,687	0	(105)	0	0	864	(788)	(900)	0	1,758
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	297	0	(32)	0	0	134	(64)	(134)	0	201
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	1,664	0	0	0	0	996	(941)	(411)	166	1,474
All other losses and special payments	0	0	0	0	0	485	(485)	0	0	0
Defence legal fees and other administration	420	0	0	0	0	209	(133)	(166)	0	330
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	18		0	0	0	16	(15)	(4)	1	16
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	838		0	0	0	0	0	0		838
Total	5,924	0	(137)	0	0	2,704	(2,426)	(1,615)	167	4,617

Non Current

Clinical negligence:-										
Secondary Care	0	0	0	0	0	0	0	0	0	0
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	0	0	0	0	0	0	0	0	0	0
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	6,307	0	0	0	0	182	0	0	0	6,489
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	0	0	0	0	0	21	(6)	0	0	15
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	43		0	0	0	0	0	(2)	0	41
2019-20 Scheme Pays - Reimbursement	37		0	0	0	0	0	(2)	0	35
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	0		0	0	0	0	0	0		0
Total	6,387	0	0	0	0	203	(6)	(4)	0	6,580

TOTAL

Clinical negligence:-										
Secondary Care	2,687	0	(105)	0	0	864	(788)	(900)	0	1,758
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	297	0	(32)	0	0	134	(64)	(134)	0	201
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	7,971	0	0	0	0	1,178	(941)	(411)	166	7,963
All other losses and special payments	0	0	0	0	0	485	(485)	0	0	0
Defence legal fees and other administration	420	0	0	0	0	230	(139)	(166)	0	345
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	61		0	0	0	16	(15)	(6)	1	57
2019-20 Scheme Pays - Reimbursement	37		0	0	0	0	0	(2)	0	35
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	838		0	0	0	0	0	0		838
Total	12,311	0	(137)	0	0	2,907	(2,432)	(1,619)	167	11,197

Expected timing of cash flows:

	In year to 31 March 2026 £000	Between 01-Apr-26 to 31 March 2030 £000	Thereafter £000	Totals £000
Clinical negligence:-				
Secondary Care	1,758	0	0	1,758
Primary Care	0	0	0	0
Redress Secondary Care	201	0	0	201
Redress Primary Care	0	0	0	0
Personal injury	1,474	1,942	4,547	7,963
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	330	15	0	345
Structured Settlements - WRPS	0	0	0	0
Pensions - former directors	0	0	0	0
Pensions - other staff	16	40	1	57
2019-20 Scheme Pays - Reimbursement	0	35	0	35
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	0	0	0	0
Other	838	0	0	838
Total	4,617	2,032	4,548	11,197

"Other" provisions of £0.838m is in relation to the dilapidation of leasehold premises.

23. Provisions (continued)

2023-24

	At 1 April 2023	Structured settlement cases transferred to Risk Pool	Transfers to creditors	Transfers between current and non current	Transfers (to)/from other NHS body	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2024
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Current										
Clinical negligence:-										
Secondary Care	1,860	0	(280)	100	0	3,401	(1,019)	(1,375)	0	2,687
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	447	0	(32)	1	0	158	(80)	(197)	0	297
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	1,883	0	0	312	0	1,537	(702)	(1,486)	120	1,664
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	512	0	0	(24)	0	355	(185)	(238)	0	420
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	16		0	6	0	10	(13)	(1)	0	18
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	386		0	0	0	546	(94)	0		838
Total	5,104	0	(312)	395	0	6,007	(2,093)	(3,297)	120	5,924
Non Current										
Clinical negligence:-										
Secondary Care	250	0	0	(100)	0	0	0	(150)	0	0
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	1	0	0	(1)	0	0	0	0	0	0
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	6,619	0	0	(312)	0	0	0	0	0	6,307
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	0	0	0	24	0	3	(4)	(23)	0	0
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	49		0	(6)	0	0	0	0	0	43
2019-20 Scheme Pays - Reimbursement	37		0	0	0	0	0	0	0	37
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	0		0	0	0	0	0	0		0
Total	6,956	0	0	(395)	0	3	(4)	(173)	0	6,387
TOTAL										
Clinical negligence:-										
Secondary Care	2,110	0	(280)	0	0	3,401	(1,019)	(1,525)	0	2,687
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	448	0	(32)	0	0	158	(80)	(197)	0	297
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	8,502	0	0	0	0	1,537	(702)	(1,486)	120	7,971
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	512	0	0	0	0	358	(189)	(261)	0	420
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	65		0	0	0	10	(13)	(1)	0	61
2019-20 Scheme Pays - Reimbursement	37		0	0	0	0	0	0	0	37
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	386		0	0	0	546	(94)	0		838
Total	12,060	0	(312)	0	0	6,010	(2,097)	(3,470)	120	12,311

24 Contingencies

24.1 Contingent liabilities

Provision has not been made in these accounts for the following amounts:

	31 March 2025 £000	31 March 2024 £000
Legal claims for alleged medical or employer negligence;		
Secondary care	11,298	6,306
Primary Care	0	0
Secondary care - Redress	0	0
Primary Care - Redress	0	0
Doubtful debts	0	0
Equal pay cases	0	0
Defence costs	291	282
Other	0	0
Total value of disputed claims	11,589	6,588
Amount recovered under insurance arrangements in the event of these claims being successful	(10,338)	(5,551)
Net contingent liability	1,251	1,037

Other litigation claims could arise in the future due to known incidents. The expenditure which may arise from such claims cannot be determined and no provision has been made for them.

Liability for Permanent Injury Benefit under the NHS Injury Benefit Scheme lies with the employer. Individual claims to the NHS Pensions Agency could arise due to known incidents.

Contingent liabilities includes claims relating to alleged clinical negligence and personal injury.

24.2. Remote contingent liabilities

	31 March 2025 £000	31 March 2024 £000
Guarantees	0	0
Indemnities	0	0
Letters of comfort	0	0
Total	0	0

24.3 Contingent assets

	31 March 2025 £000	31 March 2024 £000
	0	0
	0	0
	0	0
Total	0	0

The Trust has no contingent assets.

25. Capital commitments

Commitments under capital expenditure contracts at the statement of financial position sheet date :

The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

	31 March	31 March
	2025	2024
	£000	£000
Property, plant and equipment	2,682	346
Right of Use Assets	0	0
Intangible assets	0	0
Total	2,682	346

26. Losses and special payments

Losses and special payments are charged to the Income Statement in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore, the payments in this note for settlement and claimant costs are prepared on a cash basis.

Gross loss to the Exchequer

26.1 Number of cases and associated amounts paid out during the financial year

	Amounts paid out during year to 31 March 2025	
	No. of cases	£
Clinical negligence:-		
Secondary Care	13	787,835
Primary Care	0	0
Redress Secondary Care	19	63,934
Redress Primary Care	0	0
Personal injury	63	941,258
All other losses and special payments	261	485,194
Total	356	2,278,221

26.2 Analysis of number of cases and associated amounts paid out during the financial year

Case Type	In year cases in excess of £300,000	Cumulative amount
	L&R Case reference number	
	£	£
Cases in excess of £300,000:		

	Number of cases	£	£
Sub-total	0	0	0
All other cases paid in year	356	2,278,221	11,098,999
Total cases paid in year	356	2,278,221	11,098,999

26.3 Analysis of number of cases and associated amounts where no payments were made in financial year

	Number of cases	£
Cumulative amount up to £300k	69	877,773
Cumulative amount greater than £300k	2	1,517,758
Total	71	2,395,531

27. Right of Use / Finance leases obligations

27.1 Obligations (as lessee)

Amounts payable under right of use asset leases:

2024-25

	LAND	BUILDINGS	OTHER	TOTAL
	31 March	31 March	31 March	31 March
	2025	2025	2025	2025
	£000	£000	£000	£000
Minimum lease payments				
Within one year	0	1,322	666	1,988
Between one and five years	0	4,298	55	4,353
After five years	0	1,745	0	1,745
Less finance charges allocated to future periods	0	(286)	(10)	(296)
Minimum lease payments	0	7,079	711	7,790
Included in:				
Current borrowings	0	1,243	657	1,900
Non-current borrowings	0	5,836	54	5,890
	0	7,079	711	7,790
Present value of minimum lease payments				
Within one year	0	1,243	657	1,900
Between one and five years	0	4,140	54	4,194
After five years	0	1,696	0	1,696
Present value of minimum lease payments	0	7,079	711	7,790
Included in:				
Current borrowings	0	1,243	657	1,900
Non-current borrowings	0	5,836	54	5,890
	0	7,079	711	7,790

A contract was entered into with Airwave during 2007/08 in respect of the National Ambulance Radio Re-procurement Project. During the financial year 2019/20, the Airwave finance lease was extended to November 2022 due to the national replacement scheme being delayed. During the financial year 2022/23, this was extended again to December 2023 due to further delays. During the financial year 2023/24, this was extended again to June 2025 due to further delays. This is included within 'Other'.

2023-24	LAND	BUILDINGS	OTHER	TOTAL
	31 March	31 March	31 March	31 March
	2024	2024	2024	2024
	£000	£000	£000	£000
Minimum lease payments				
Within one year	0	1,359	2,252	3,611
Between one and five years	0	4,742	629	5,371
After five years	0	2,790	0	2,790
Less finance charges allocated to future periods	0	(337)	(90)	(427)
Minimum lease payments	0	8,554	2,791	11,345
Included in:				
Current borrowings	0	1,281	2,167	3,448
Non-current borrowings	0	7,273	624	7,897
	0	8,554	2,791	11,345
Present value of minimum lease payments				
Within one year	0	1,281	2,167	3,448
Between one and five years	0	4,554	624	5,178
After five years	0	2,719	0	2,719
Present value of minimum lease payments	0	8,554	2,791	11,345
Included in:				
Current borrowings	0	1,281	2,167	3,448
Non-current borrowings	0	7,273	624	7,897
	0	8,554	2,791	11,345

27.2 Right of Use Assets receivables (as lessor)

The Trust has no amounts receivable under right of use asset or finance leases as lessor.

Amounts receivable under right of use assets:

	31 March 2025 £000	31 March 2024 £000
Gross investment in leases		
Within one year	0	0
Between one and five years	0	0
After five years	0	0
Less finance charges allocated to future periods	0	0
Present value of minimum lease payments	0	0
Included in: Current financial assets	0	0
Non-current financial assets	0	0
Total	0	0
Present value of minimum lease payments		
Within one year	0	0
Between one and five years	0	0
After five years	0	0
Less finance charges allocated to future periods	0	0
Total present value of minimum lease payments	0	0
Included in: Current financial assets	0	0
Non-current financial assets	0	0
Total	0	0

27.3 Finance Lease Commitment

The Trust does not have any commitments becoming operational in a future period.

28. Private finance transactions

Private Finance Initiatives (PFI) / Public Private Partnerships (PPP)

The Trust has no PFI or PPP Schemes.

29. Financial Risk Management

IFRS 7, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

NHS Trusts are not exposed to the degree of financial risk faced by business entities. Financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. NHS Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing NHS Trusts in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust treasury activity is subject to review by the Trust's internal auditors.

Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with various Health bodies, which are financed from resources voted annually by parliament. NHS Trusts also largely finance their capital expenditure from funds made available from the Welsh Government under agreed borrowing limits. NHS Trusts are not, therefore, exposed to significant liquidity risks.

Interest-rate risks

The great majority of NHS Trust's financial assets and financial liabilities carry nil or fixed rates of interest. NHS Trusts are not, therefore, exposed to significant interest-rate risk.

Foreign currency risk

NHS Trusts have no or negligible foreign currency income or expenditure and therefore are not exposed to significant foreign currency risk.

Credit Risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures are in receivables from customers as disclosed in the trade and other receivables note.

General

The powers of the Trust to invest and borrow are limited. The Board has determined that in order to maximise income from cash balances held, any balance of cash which is not required will be invested. The Trust does not borrow from the private sector. All other financial instruments are held for the sole purpose of managing the cash flow of the Trust on a day to day basis or arise from the operating activities of the Trust. The management of risks around these financial instruments therefore relates primarily to the Trust's overall arrangements for managing risks to their financial position, rather than the Trust's treasury management procedures.

30. Movements in working capital

	31 March 2025 £000	31 March 2024 £000
(Increase) / decrease in inventories	5	(87)
(Increase) / decrease in trade and other receivables - non-current	(13)	(8)
(Increase) / decrease in trade and other receivables - current	2,112	1,664
Increase / (decrease) in trade and other payables - non-current	(2,007)	(503)
Increase / (decrease) in trade and other payables - current	(9,542)	(1,928)
Total	(9,445)	(862)
Adjustment for accrual movements in fixed assets - creditors	6,166	(5,039)
Adjustment for accrual movements in fixed assets - debtors	0	0
Adjustment for accrual movements in right of use assets - creditors	3,331	59
Adjustment for accrual movements in right of use assets - debtors	0	0
Other adjustments	6	151
Total	58	(5,691)

The 'Other adjustments' relates to the amount owed to WG in relation to PIBS funding for 24/25.

31. Other cash flow adjustments

	31 March 2025 £000	31 March 2024 £000
Other cash flow adjustments		
Depreciation	18,263	17,634
Amortisation	1,137	669
(Gains)/Loss on Disposal	0	0
Impairments and reversals	1,718	6,655
Release of PFI deferred credits	0	0
NWSSP Covid assets issued debited to expenditure but non-cash	0	0
NWSSP Covid assets received credited to revenue but non-cash	0	0
Donated assets received credited to revenue but non-cash	0	0
Government Grant assets received credited to revenue but non-cash	0	0
Right of Use Grant (Peppercorn Lease) credited to revenue but non cash	0	0
Non-cash movements in right of use assets	0	0
Non-cash movements in provisions	1,318	2,348
Total	22,436	27,306

32. Events after reporting period

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 26/06/2025; the financial statements were then certified by the Auditor General for Wales on 27/06/2025.

33. Related Party Transactions

The Welsh Government is regarded as a related party. During the year the LHB have had a significant number of material transactions with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body, namely

Related Party	Expenditure to related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Welsh Government	1,953	23,260	7	564
JCC	0	275,441	319	48
Aneurin Bevan University Health Board	257	701	74	407
Betsi Cadwaladr University Health Board	529	1,750	145	430
Cardiff & Vale University Health Board	135	447	51	174
Cwm Taf Morgannwg University Health Board	82	815	19	744
Hywel Dda University Health Board	111	1,660	38	23
Powys Teaching Health Board	66	(3)	3	7
Swansea Bay University Health Board	163	782	20	48
Public Health Wales NHS Trust	5	178	0	44
Velindre University NHS Trust	2,137	1,337	463	136
Health Education and Improvement Wales (HEIW)	3	1,039	3	16
Digital Health & Care Wales (DHCW)	1,490	101	0	0
Welsh Local Authorities	2,208	361	47	73
	9,139	307,869	1,189	2,714

The Trust Board is the Corporate Trustee of the Welsh Ambulance Services NHS Trust Charity. All voting members of the Trust can act as a corporate trustee of the Charity. During the year receipts from the Charity amounted to £0.010m (2023/24 £0.010m) with no other transactions being made. Net assets of the Charity amount to £0.762m.

The Welsh Government income shown above includes £1.718m relating to impairment funding.

Jason Killens, Chief Executive, is both a Member of the Order St John and Honorary Professor at Swansea University and took up the role of Chairperson of the Association of Ambulance Chief Executives (AACE) from September 2024. The transactions disclosed with AACE are for the period September 2024-March 2025 only.

Lee Brooks, Executive Director of Operation, is also a Member of the Order of St John and a Council Member of St John's Ambulance Cymru Gwent Council.

Hayley Hutching, Non-Executive Director, is employed at Swansea University as Professor of Health Services Research.

33. Related Party transactions (continued)

A number of the Trust's members have declared interests in related parties.

The register of Declarations of Interest for the Trust's members can be found on the Trust website:

[Board Member Register of Interests - Live.xlsx](#)

No other Trust members provided declarations of interest in related parties during the period.

Material transactions between the Trust and related parties disclosed on the register of Declarations of Interest for 2024-25 were as follows (unless already reported on page 71):

	Payments to related party £000	Receipts from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Association of Ambulance Chief Executives	3	65	0	0
St John Ambulance	3,186	0	356	0
Swansea University	20	128	0	64
TOTAL	3,209	193	356	64

34. Third party assets

The Trust has no third party assets.

35. Pooled budgets

Welsh Ambulance Services University NHS Trust has no pooled budgets.

36. Operating Segments

IFRS 8 requires organisations to report information about each of its operating segments.

The Trust's primary remit is the provision of Ambulance and Unscheduled Care services throughout Wales and this is viewed as the only segment that is recognisable under this legislation.

The Chief Operating Decision Maker (CODM) is considered to be the Trust Board. The CODM receives a variety of information in a variety of formats dealing with various aspects of ambulance service and NHS Direct Wales performance. The Trust however considers the provision of services to be ultimately generic, in terms of geography and service.

The Trust therefore is deemed to operate as one segment.

37. Other Information

Staff

The value of notional transactions is based on estimated costs for the twelve month period 1 April 2024 to 31 March 2025. This has been calculated from actual Welsh Government expenditure for the 9.4% staff employer pension contributions between April 2024 and February 2025 alongside Trust data for March 2025.

Transactions include notional expenditure in relation to the 9.4% paid to NHS BSA by Welsh Government and notional funding to cover that expenditure as follows:

	2024-25	2023-24
STATEMENT OF COMPREHENSIVE INCOME		
FOR THE YEAR ENDED 31 MARCH 2025	£000	£000
Revenue from patient care activities	14,577	9,196
Operating expenses	14,577	9,196
3. Analysis of gross operating costs		
3. Revenue from patient care activities		
Welsh Government	14,577	9,196
Welsh Government - Hosted Bodies	0	0
5.1 Operating expenses		
Directors' costs	115	67
Staff costs	14,462	9,129

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Other

37.2 IFRS 17 - Insurance Contract Disclosures

The outcome of the contract review for a range of income contract types applicable to the organisation, did not identify any insurance contracts that fall within the scope of IFRS 17.

STATEMENT OF FINANCIAL POSITION

(Signage as per provision note disclosure)	£000
Liability for incurred claims @ 1 April 2024	0
Liability for remaining payments @ 31 March 2025	0
	0
Arising during year	0
Utilised	0
Reversed unused	0
Movement in Discount Rates	0
	0

STATEMENT OF COMPREHENSIVE NET EXPENDITURE / STATEMENT OF COMPREHENSIVE INCOME

(Signage as per income and expenditure note disclosure)	£000
Insurance Income	0
Insurance expenditure	0

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

NHS TRUSTS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2010 and subsequent financial years in respect of the NHS Wales Trusts in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the NHS Wales Trusts shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year for which the accounts are being prepared, as detailed in the NHS Wales Trust Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the Trust for the year ended 31 March 2010 and subsequent years shall comprise a foreword, an income statement, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied to the NHS Wales Manual for Accounts, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2010 and subsequent years, the account of the Trust shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst

Dated : 17.06.2010

1 Please see regulation 3 of the 2009 No 1558(W.153); NATIONAL HEALTH SERVICE, WALES; The National Health Service Trusts (Transfer of Staff, Property Rights and Liabilities) (Wales)



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AGENDA ITEM No	13.2
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

ANNUAL REPORT 2024-25

MEETING	Audit, Risk and Assurance Committee
DATE	24 June 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/ Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance and Risk Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Trust submitted its draft Annual Report 2024-25 on 09 May 2025 to Audit Wales and Welsh Government in line with the agreed timetable as prescribed by the 2024-25 Manual for Accounts.
2. Comments from both Audit Wales and Welsh Government have been incorporated into the final Annual Report, which is attached for review and endorsement by the Audit, Risk and Assurance Committee.

RECOMMENDATION:

3. **That the 2024-25 Annual Report be recommended for formal approval by the Trust Board.**

KEY ISSUES/IMPLICATIONS

4. The Annual Report includes the Performance Report and the Accountability Report. Both have been developed in accordance with the NHS Wales 2024-25 Manual for Accounts.
5. The Accountability Report includes the Statement of Directors' responsibilities in respect of the Accounts (page 111) which will be signed by order of the Board by the Chair, Chief Executive and Executive Director of Finance and Corporate Resources.



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6. Welsh language translation of the Annual Report and the foreword section of the Accounts is in progress and will be finalised once the Annual Report and Accounts have been approved by the Board.

REPORT APPROVAL ROUTE

- The draft annual report with the draft remuneration table was circulated to the Board for comment before submission to Welsh Government and Audit Wales on the 09 May 2025.
- Welsh Government and Audit Wales have received and commented on the draft Annual Report and their comments have been addressed and closed off.
- A further review of the annual report was undertaken by the Executive Leadership Team via email circulation w/c 09 June 2025.

REPORT APPENDICES

Annex 1 - Annual Report 2024-25

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	YES
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA



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ANNUAL REPORT 2024/25

SITUATION

7. The Trust submitted its Draft Annual Report 2024-25 on 09 May 2025 to Audit Wales and Welsh Government in line with the agreed timetable. Comments from both Audit Wales and Welsh Government have been incorporated into the final Annual Report which is attached for review and endorsement by the Audit, Risk and Assurance Committee.

BACKGROUND

8. The Annual Report, which consists of Part 1 - Performance Report and Part 2 – Accountability Report, have been prepared in accordance with the NHS Wales 2024-25 Manual for Accounts Chapter 3.
9. A Task and Finish Group was established for the development of the Annual Report. The Group coordinated contributions to the Annual Report from across the Trust and will submit its closing report to the Assistant Directors' Leadership Team for receipt in August. It is anticipated that the Group will be re-established for the 2025-26 Annual Report production.

ASSESSMENT

10. Following submission of the draft Annual Report to Audit Wales and Welsh Government on 09 May 2025 comments were provided relating to both the Performance Report and Accountability Report which have been addressed. The feedback and queries received from Audit Wales and Welsh Government were minimal and resulted in minor adjustments to the narrative.
11. This Annual Report is part of a suite of documents that provides information about the Trust. In accordance with the NHS Wales 2024/25 Manual for Accounts and HM Treasury's Financial Reporting Manual, the Annual Report for 2024/25 includes:
 - **Part 1: Performance Report** which details how the Trust performed in the year. There are key quality themes included within the Performance Report narrative, as well as a separate Quality Governance statement within the Accountability Report. In line with the requirement to prepare a formal Duty of Quality Annual Report for 2023-24, the Trust has prepared a Report for the 2024-25 year which is before the Committee separately.



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- **Part 2: Accountability Report** which details the key accountability requirements, and our Governance Statement provides information about how the Trust manages and controls resources and risks and complies with governance arrangements. It includes the Corporate Governance Report (including the Governance Statement), the Remuneration and Staff Report, and the Parliamentary Accountability and Audit Report.
12. The Accountability Report includes the Statement of Directors' responsibilities in respect of the Accounts (page 111) which will be signed by order of the Board by the Chair, Chief Executive and Executive Director of Finance and Corporate Resources. The Remuneration Table (pages 176-179) has been reviewed by Remuneration Committee members and the Executive Leadership Team.
13. The Annual Report and 'foreword section of the Accounts are in the process of being translated for presentation at the Annual General Meeting on the 31 July 2025. The full financial accounts will not be translated. This is due to the complexity of the document where translation of complex excel workbooks poses risk of errors and a significant workload from the finance and audit teams.
14. The Welsh Government Manual for Accounts 2024-25 requires the Trust to submit as a single PDF document a three-part Annual Report and Financial Accounts. For this submission, the document attached will be entitled Annual Report and Financial Accounts 2024-25 and include the Financial Statements as 'Part 3'. This is required to be submitted to Welsh Government by 30 June 2025.
15. Planning for the 2025-26 Annual Report will start earlier this year to reduce the content of both Part 1 and Part 2. This will involve coordinating efforts for the IMTP 'state of the nation', the Duty of Quality report, and the end-of-year JET presentation, and the use of AI to improve efficiency.

RECOMMENDATION

16. **That the 2024-24 Annual Report be recommended for formal approval by the Trust Board.**



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Annual Report and Accounts 2024/25

INTRODUCTION

This Annual Report is part of a suite of documents that provides information about the Welsh Ambulance Services University NHS Trust (the Trust). It will provide the reader with information on our services, the care we provide and what we do to plan, deliver, and improve those services. In addition, it will provide the reader with detail on the Trust's performance and how we responded to changing demands and challenges in 2024/25.

In accordance with the NHS Wales 2024/25 Manual for Accounts and HM Treasury's Financial Reporting Manual, our Annual Report for 2024/25 includes: -

Part 1: Performance Report which details how the Trust performed in the year and how we adapted and responded to the system pressures currently impacting our patients and our people.

Part 2: Accountability Report which details the key accountability requirements and our Governance Statement, which provides information about how the Trust manages and controls resources and risks and complies with governance arrangements.

Part 3 Financial Statements which detail how the Trust has spent its money and met its obligations. These accounts for the period ended 31 March 2025 have been prepared to comply with International Financial Reporting Standards (IFRS) adopted by the European Union, in accordance with HM Treasury's FReM by the Welsh Ambulances Services NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed.

For 2024/25, a separate Duty of Quality Report has been prepared and the disclosures required in line with the Duty of Candour reporting will be included in the Annual Putting Things Right Report for 2024/25 (which will be published in late 2025 and reported via the Trust's corporate governance structures).



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Whilst acronyms are explained in full when they are first used, a glossary is included on page 8 for ease of reference. If you require a version of the Annual Report in printed form, please contact the Director of Corporate Governance / Board Secretary at Trish.Mills@wales.nhs.uk.

Mae'r ddogfen hon ar gael yn Gymraeg / This document is available in Welsh. The Welsh Language version of the 2024/25 Annual Report will be available on the Trust's '[Publications](#)' page after the 2025 Annual General Meeting has been held.

WELCOME MESSAGE FROM THE CHAIR AND CHIEF EXECUTIVE OFFICER

Welcome to the Welsh Ambulance Services University NHS Trust Annual Report for 2024/25. We hope that this document is helpful in reflecting on the year, both challenges and changes, as well as providing an opportunity to look ahead at the year to come.

The NHS is very much a “people business”, and that is certainly true of the ambulance service, which is nothing without the exceptional people we employ and who volunteer for us, in a multiplicity of patient facing and support roles, without whom the organisation would be unable to function.

It is true to say that everyone plays a huge part in delivering the best we possibly can for our patients, regardless of their role. As ever, 2024/25 has not been without its challenges and it is testament to our people that we have been able to deliver so much in the face of unrelenting demand, pressures at the front door of emergency departments and new ways of working, which take time and resilience to adjust to.

This year, we have focused heavily on working with our partners across NHS Wales and with government on really getting underneath what needs to change in order for patients to be better served by the ambulance service, whether that be in terms of face to face or remote care.

An astonishing amount of work was undertaken by staff across our organisation to develop a new system to support our 111 service early on in the year, which went from design to implementation in six months. Similarly, a huge amount of work has gone into both testing new approaches to support patients, particularly over the winter period, which will now inform the future development of our clinical model.

In the autumn of 2024, the Cabinet Secretary for Health and Social Care announced a review of our long-standing “RED” target, following recommendations made by the Senedd’s Health and Social Care Committee.

This involved the establishment of a task and finish group to review the clinical appropriateness of the target, resulting in an announcement in March 2025 that, with effect from July 1, 2025, a new performance framework will be implemented for a trial period of a year, with a focus on clinical outcome measurement, rather than just a time-based response. The whole aim is to ensure more people survive life threatening episodes, including cardiac arrest, with a long-term aim of making Wales a nation of lifesavers.

I hope this introduction has whetted your appetite to read on and find out more. Of course, we would also encourage you to attend our Annual General Meeting later in the year and to keep an eye on social media for the latest news and developments. In the meantime, thanks to you all for your continued support.

With our very best wishes,

Colin Dennis

Chair of the Trust Board



Jason Killens

Chief Executive Officer



REPORT CONTENTS

INTRODUCTION	2
WELCOME MESSAGE FROM THE CHAIR AND CHIEF EXECUTIVE OFFICER.....	4
PART 1: – PERFORMANCE REPORT	11
PERFORMANCE OVERVIEW	11
1.1. Introduction.....	11
1.2. Statement from the Chief Executive Officer	11
1.3. Areas of Responsibility	14
1.4. Our Purpose and Long-Term Strategy	15
1.5. Integrated Medium-Term Plan (IMTP).....	16
1.6. Evolving Our Integrated Clinical Services Model.....	17
1.7. Performance Summary.....	20
1.7.1 Our Patients – Quality, Safety and Patient Experience	22
1.7.2 Our People	31
1.7.3 Finance and Value	34
1.7.4 Partnerships and Systems Contributions	36
1.7.5 Integrated Medium-Term Plan (IMTP) Delivery	39
1.7.6 Managing Risk	40
DELIVERY AND PERFORMANCE ANALYSIS	41
1.8 Our Patients (Quality, Safety and Patient Experience).....	41
1.9 Our People	63
1.10 Finance and Value	68
1.11 Non-Financial Performance Information	69
1.12 Partnerships and System Contribution.....	69
1.13 Infection Prevention and Control	74
1.14 IMTP delivery.....	75
1.15 Ministerial Priorities and NHS Wales.....	77

1.16 Accountability Conditions	84
1.17 Workforce Management and Well-being.....	87
1.18 Decision-making and Governance	92
1.19 Conclusions and Look Forward	96
1.20 Links to Further Information.....	98
PART 2: - ACCOUNTABILITY REPORT	100
2.1 Corporate Governance Report	101
2.1.1 The Directors' Report.....	102
2.1.2 Statement of Accountable Officer's Responsibilities	109
2.1.3 Statement of Directors' responsibilities in respect of the Accounts ..	111
2.1.4 The Governance Statement.....	113
2.2 Modern Slavery Act 2015 – Transparency in Supply Chains.....	170
2.3 Remuneration and Staff Report	171
2.4 Senedd Cymru/Welsh Parliamentary Accountability and Audit Report..	188
PART 3: - FINANCIAL STATEMENTS	196

GLOSSARY OF TERMS

Abbreviation	Term
AAA	Alert, Assure, Advise Report
ACA1/2	Ambulance Care Assistant
ADLT	Assistant Directors' Leadership Team
AGM	Annual General Meeting
APC	Academic Partnership Committee
APPs	Advanced Paramedic Practitioners
APR	Adult Practice Reviews
ARAC	Audit, Risk and Assurance Committee
ARWAP	Anti Racist Wales Action Plan
BAF	Board Assurance Framework
BI	Business Intelligence
CVUHB	Cardiff and Value University Health Board
CAS	Clinical Assessment System
CC	Charity Committee
CCC	Clinical Contact Centres
CFRs	Community First Responders
CHARU	Cymru High Acuity Response Unit
CMT	Clinical Model Transformation
CPR	Child Practice Reviews
CardioPR	Cardiopulmonary Resuscitation
CRM	Clinical Response Model
CRR	Corporate Risk Register
CQGG	Clinical Quality Governance Group
CSD	Clinical Support Desk
DAP	Decarbonisation Action Plan
DEEE	Diesel Engine Exhaust Emissions
DPIA	Data Protection Impact Assessments
EAP	Emergency Ambulance Practitioner
EASC	Emergency Ambulance Services Committee
EDs	Emergency Departments
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
ELT	Executive Leadership Team
ePCR	Electronic Patient Care Record
EPRR	Emergency Preparedness, Resilience, and Response
ESR	Electronic Staff Record

GLOSSARY OF TERMS

Abbreviation	Term
GRS	Global Rostering System
HART	Hazardous Area Response Team
HEIW	Health Education and Improvement Wales
HIW	Health Inspectorate Wales
HSE	Health and Safety Executive
FPC	Finance and Performance Committee
FReM	Government Financial Reporting Manual
FTE	Full-time Equivalent
HSE	Health and Safety Executive
ICAP	Integrated Commissioning Action Plan
ICO	Information Commissioner's Office
IMTP	Integrated Medium-Term Plan
IPC	Infection Prevention Control
JCC	NHS Wales Joint Commissioning Committee
LCFS	Local Counter Fraud Service
LRF	Local Resilience Forum/Fora
MAI	Manchester Arena Inquiry
MHRV	Mental health response vehicle
MIQPR	Monthly Integrated Quality and Performance Report
PENNA	National Patient Experience Network Awards
NEPTS	Non-Emergency Patient Transport Service
NQP	Newly Qualified Paramedic
NRIs	National Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
PADRs	Performance and Development Reviews
PCC	People and Culture Committee
PECI	Patient Experience and Community Involvement
PSOW	Public Service Ombudsman for Wales
QIA	Quality Impact Assessments
QMG	Quality Management Group
QPMF	Quality and Performance Management Framework
QuEst	Quality, Patient Experience and Safety Committee
RemCom	Remuneration Committee
RCRP	Right Care Right Person
RCS	Rapid Clinical Screening
RICS	Remote Integrated Care Service

GLOSSARY OF TERMS

Abbreviation	Term
RPE	Respiratory Protective Equipment
RRB	Regional Partnership Boards
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
RIF	Regional Integration Fund
ROSC	Return of spontaneous circulation from cardiac arrest
SCIF	Significant Clinical Incident Forum
SDECs	Same Day Emergency Care Centres
SI	Statutory Instrument
SOP	Standard Operating Procedure
SORT	Specialist Operational Response Team
STB	Strategic Transformation Board
STEMI	ST segment elevation myocardial infarction
SUS	Speaking Up Safely
The Trust	Welsh Ambulance Services University NHS Trust
TRiM	Trauma and Risk Management Network
TU	Trade Union
UCRS	Urgent Community Response Service
UCS	Urgent Care Service
UHP	Unit Hour Production
UTS	University Trust Status
WASPT	Welsh Ambulance Services Partnership Team
WHSCC	Welsh Health Specialised Services Committee
WRP	Welsh Risk Pool
WTEs	Whole-time equivalents

PART 1: – PERFORMANCE REPORT

PERFORMANCE OVERVIEW

1.1. Introduction

This Performance Overview aims to provide an integrated quality, patient safety, patient experience, and performance narrative on the Welsh Ambulance Services University NHS Trust (the Trust) for the period 01 April 2024 to 31 March 2025. The Performance Report is produced in line with the requirements of the NHS Wales 2024/25 Manual for Accounts.

1.2. Statement from the Chief Executive Officer

The 2024/25 year has been another challenging year for the Trust with continued high pressure across the health and social care system. Whilst the pressure has remained high, there has been some improvements in performance in certain areas.

Because of the very challenging system pressures the Trust is operating in and subsequent impact on avoidable patient harm, the Trust took the decision to begin implementing its Clinical Model Transformation Programme in 2024/25 and switch on key aspects of the programme for, and during, Winter 2024/25. These changes, in particular, rapid clinical screening by a clinician early in the emergency ambulance pathway, have led to a reduction in patients cancelling their 999 calls and the Trust not saying it “can’t send” an ambulance.

Due to circumstances beyond the Trust’s control, the 111 Service had to implement the new 111 Clinical Assessment System (CAS) at real pace. This major change did impact on recruitment, which in turn affected performance. The call abandonment rate monthly average increased to 10.4% during 2024/25, up from 6.2% the year before and above 5% target. The percentage of calls answered within 60 seconds, also declined, falling from an average answer rate of 55.3% in 2023/24 to 38.8% in 2024/25. The Trust is currently engaged in an independent review of its 111 capacity and rostering practice.

For 999 callers, our headline target is to respond to 65% of Red (immediately life threatening) calls in eight minutes. The Trust did not achieve this target during any month in 2024/25 with the highest percentage rate of 51.8% being achieved in August; however, it did see a further improvement in the number of patients within the Red category being reached within eight-minutes with the average monthly rate increasing from 2,227 in 2023/24 to 2,591 in 2024/25. On the 11 March 2025 the Cabinet Secretary for Health and Social Care announced that the current Red category will be replaced with a new arrest category and emergency category from 01 July 2025, with the focus moving to measures of the chain of survival and patient outcomes i.e. saving lives, rather than a hit/miss time target.

Patients in the Amber category (serious, but not immediately life threatening) also saw a deterioration in their waiting times, with the average wait time for the year being 1 hour 47 minutes, compared to 1 hour 19 minutes in 2023/24. It has been identified there is a clear correlation between hospital handover lost hours and higher Amber response times and the increasing number of hours lost during hospital handovers remains a key contributory factor for these longer response times. Overall waiting times in the community and at hospital are still far too long and the Trust knows that avoidable harm has occurred as a result. The Clinical Model Transformation (CMT) programme is the Trust's strategic response.

The Non-Emergency Patient Transport Service (NEPTS) achieved its headline renal appointments time in nine of the twelve months during 2024/25 and achieved the target for all twelve months in relation to its Oncology appointments. Whilst the NEPTS headline metrics are positive, the Trust knows it is not reaching all patients who need the service. The Trust is taking a range of actions to help address this, including the introduction of two way texting with patients, aimed at reducing last minute cancellations; and improving the alignment of the service to patient demand. The Trust is also engaging with its commissioners regarding the greater capacity that is likely to be required to sustain existing levels of service.

Patient handover lost hours at emergency departments continued to be the single biggest inefficiency of the Trust's resources. Although handover lost hours reduced in 2023/24, they have risen over the past year, averaging 22,003 hours per month during 2024/25 compared to 21,700 a month in 2023/24. This meant the Trust lost 264,393 ambulance hours over the course of the year and could have responded to 41,448 more patients if these hours had not been lost.

Despite these on-going pressures, our people have continued to deliver, taking action to improve services for patients and for staff and volunteers. The Trust increased its Cymru High Acuity Response Unit (CHARU) establishment to 122.5 full-time equivalents (FTEs), grew the number of Advanced Paramedic Practitioners (APPs) by 24.4 FTEs, saw the Emergency Medical Service (EMS) abstraction rate achieve its benchmark for three consecutive months, and further reduced its monthly sickness absence rate to 7.86%.

We are now in the second year of our ambitious CMT Programme, which represents a fundamental shift in how we deliver care, moving towards a fully integrated and patient-centred model. This transformation is crucial to our strategic objective to provide the right care or advice, in the right place, every time.

The Trust is open and transparent in its monthly reporting of patient experience, patient safety, and performance and the Annual Performance Report provides a fair and balanced assessment of how the Trust is doing.

Finally, I want to thank all of our staff and volunteers, blue light partners, commissioners, the private sector, and the voluntary sector for their continued support.

Jason Killens

Welsh Ambulance Services University NHS Trust Chief Executive Officer

Date: 26 June 2025

1.3. Areas of Responsibility

The Trust provides health care services for people across the whole of Wales, delivering high quality and patient-led clinical care wherever and whenever needed.

Services include: -

- The blue light emergency ambulance services: including call taking, remote clinical consultation, see and treat and if necessary, conveyance to an appropriate hospital or treating facility.
- NEPTS: including call taking, journey planning, service commissioning, taking patients to and from hospital appointments and transferring them between hospitals and treating facilities.
- The 111 service: website and a free-to-call service, acts as a first line gateway to a patient's journey within the health and care system providing them with the right advice or referral.
- The Trust also supports volunteers: Community First Responders (CFRs), Community Welfare Responders (CWRs) and Uniformed Responders to provide additional response resource to emergency calls and a Volunteer Car Service to aid patient transport to planned appointments.

The Trust is a commissioned service for EMS, NHS Wales 111 and Ambulance Care. As of 01 April 2024, the NHS Wales Joint Commissioning Committee (JCC) replaced both the Emergency Ambulance Services Committee (EASC) and the Welsh Health Specialised Services Committee (WHSSC). The JCC is a joint committee of the seven Health Boards, with the Trust attending JCC meetings as observers. It has responsibility for the planning and commissioning of emergency ambulance services including NHS Wales 111 and specialised services which were previously provided by WHSSC, on an All-Wales basis. The Trust has engaged constructively with the JCC and its governance structures and range of commissioning intentions and desired metrics each year.



1.4. Our Purpose and Long-Term Strategy

Our Purpose

In 2023 we adopted our organisational purpose statement '**To Support, To Serve, To Save**'. This short but powerful statement seeks to describe the organisations 'core' reason for being, uniting all of people towards a common goal.



Our Strategic Objectives



Our Long-Term Strategic Framework '**Delivering Excellence**' sets out the future vision for the organisation up to 2030. The strategy is framed around the transformation of our clinical services model to ensure that patients receive the '**right advice and care, in the right place, every time**'. Our ambition is to evolve from a traditional ambulance and transport service, towards an integrated clinical service which works in collaboration with the health and care system to best meet the needs of patients who contact us through 111, 999 and our non-emergency services in a way which makes the most of the Welsh pound, adding value to the system within which we work.





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However, Delivering Excellence is a whole organisational strategy, not only concerned with service models, but also with how we support and enable **our people to be the best that they can be**. We also commit within the strategy to being an organisation that **collaborates** with our partners, stays at the **forefront of innovation and technology**, fulfils our duties as a **quality driven and clinically led organisation** that delivers exceptional **value**. We have continued to develop our annual plans (Integrated Medium-Term Plan) around this strategy and its **six core strategic objectives**.

1.5. Integrated Medium-Term Plan (IMTP)

At an organisational level, the Integrated Medium-Term Plan (IMTP) sets out, on a three-year rolling basis, the prioritised actions that the Trust will take to move it towards its strategic objectives. The IMTP considers the national planning guidance issued by Welsh Government, the external environment in which the Trust operates including statutory requirements and commissioning intentions, the risks it is managing, as well as intelligence gathered from patients, staff, and volunteers.

In particular the Trust was required to articulate through the IMTP how it planned to deliver on the priorities set by the Cabinet Secretary for Health and Social Care in Wales. The Trust Board approved the IMTP for 2024-27 and submitted it to Welsh Government at the end of March 2024, and it was formally approved in August 2024. The Trust reviews its performance against the commitments within the IMTP both through tracking of actions and deliverables at the Strategic Transformation Board (STB) and analysis of key metrics within the Monthly Integrated Quality and Performance Report (MIQPR).

In 2024 we also developed a set of statements to consider what good would look like as a result of transformational change and IMTP delivery. The graphic below shows that in some areas we are moving towards the position we wanted to as set out last year, but we know there are still some areas that have deteriorated, and further improvement is required this year to address these areas, as well as further advance the outcomes towards the anticipated outcomes set out in our plans.



1.6 Evolving Our Integrated Clinical Services Model

We are now in the second year of our ambitious CMT Programme, evolving our Clinical Response Model (CRM) into an integrated Clinical Services Model. This transformation is crucial to our strategic objective to provide the **right care or advice, in the right place, every time**.

The programme represents a fundamental shift in how the Trust will deliver care, transitioning from a conveyance-based emergency response focus to an integrated, patient-centred model that connects our core services into a cohesive system. This approach allows the Trust to better meet the healthcare needs of the people of Wales by offering a broader range of care options, including addressing urgent and emergency needs within the community.

In its first year, the programme prioritised rapid service developments to enhance safety over the winter period. This year, we are laying the groundwork for a fully integrated service while deepening collaboration with system partners to refine and test the proposed model, ensuring alignment with the wider urgent and emergency care system.

The evolved CMT programme is designed to be clinically led, patient centred and integrated across multiple services. To deliver this transformation, we will:

- **Embed clinically-led decision making:** Clinical expertise will guide care decisions from the first patient contact, ensuring timely, personalised responses, reducing unnecessary interventions, and improving outcomes.
- **Enhance system connectivity:** Systems, processes, and our people will be integrated across the Trust, supported by digital solutions to deliver consistent patient experiences and maximise resource efficiency.
- **Offer choice through diversified response options:** Expanding response pathways will allow safe, community-based treatments while ensuring ambulance dispatch is prioritised for critical needs.
- **Strengthen collaborative pathways:** Partnerships with Health Boards, commissioners, and community services will be developed to create shared care pathways, enabling staff to connect patients to the most appropriate local services.

The CMT Programme is structured around five core workstreams, supported by a cross-organisational governance framework to ensure alignment with strategic priorities and efficient resource use: -

Online Digital Advice

We will provide patients with a modern, integrated digital platform through NHS111 Wales. This platform will improve accessibility to timely and accurate health information.

Remote Integrated Care Services (RICS)

This fully integrated service will be the cornerstone of our integrated clinical services model. Clinicians will have access to an expanded range of clinical pathways internally and within Health Boards, including remote monitoring and specialist resources, ensuring personalised care. It is our intention to align pathways and processes but also bring together remote clinical capacity in the Clinical Support Desk (CSD) and 111 as an integrated remote clinical assessment team in 2025/26.

Urgent Community Response Service (UCRS)

Where existing pathways of care do not exist within the community, we will implement a consistent approach to urgent community care across Wales. This service offering is designed to better meet the needs of our patients who present through 999 and 111, where historically an ambulance dispatch would have been the only option. It will include face-to-face interventions, such as rapid falls response, advanced paramedic care, and mental health crisis intervention. This approach will improve access to community-based care, prevent unnecessary emergency department conveyance, and ensure equitable service delivery.

Emergency Response Service

Our traditional emergency response model will transition to a clinically prioritised system, incorporating Rapid Clinical Screening (RCS) for 999 calls. This will ensure emergency cases are prioritised based on clinical need, enabling timely responses for critical incidents while connecting other patients to appropriate remote or community care pathways.

In 2024/25, we introduced the Clinical Navigator role – senior clinicians who assess incoming calls for suitability for remote management through the RICS. This innovation enhances clinical oversight and enables a more nuanced approach to patient triage, focusing on what care is required rather than defaulting to ambulance dispatch.

Alongside this, we implemented RCS for Green and Amber category calls through a phased rollout, completed by February 2025. Early data shows that 75% of screened cases were suitable for further remote management, with consult and close rates approaching modelled targets, demonstrating the system's potential to improve patient flow and care outcomes.

Health Transport Service

Patients with known, routine care needs will have timely access to a responsive, planned health transport service that connects seamlessly with the wider care system. Following a RICS intervention, suitable journeys will be identified and coordinated through an integrated transport model that optimises resources and supports safe, efficient transfer to the right place of care. This system will reduce unnecessary dispatches, improve flow across services, and enhance the overall patient experience for scheduled and non-urgent care.

The CMT Programme represents a fundamental shift in how we deliver care, moving towards a fully integrated and patient-centred model. By leveraging innovation, fostering collaboration, and embedding clinical leadership, we will ensure that our services remain responsive to the needs of our communities. This transformation is not just about meeting current challenges but building a resilient healthcare system for the future – one that provides the right care or advice, in the right place, every time.

1.7 Performance Summary

The Trust has a Quality and Performance Management Framework (QPMF), approved by the Trust Board. A requirement of the Framework is to look at quality and performance in a balanced and consistent way. The Trust uses four lenses to do so: -

- Our Patients;
- Our People;
- Finance and Value; and
- Partnerships and System Contribution.

These four headings are used in the following sections to review the Trust's performance in 2024/25 and are based on Welsh Government's 'quadruple aims' for health and social care. The Trust Board receives an in-year (MIQPR) every two months which provides the latest position on key performance indicators against these four headings. This top-level report is supported by a comprehensive range of more specific reports to each Board Committee and the Executive Leadership Team (ELT).

A subsequent key development has been the publication of the Ministerial Six Goals for Urgent and Emergency Care, which sets out expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place first time for physical and mental health.

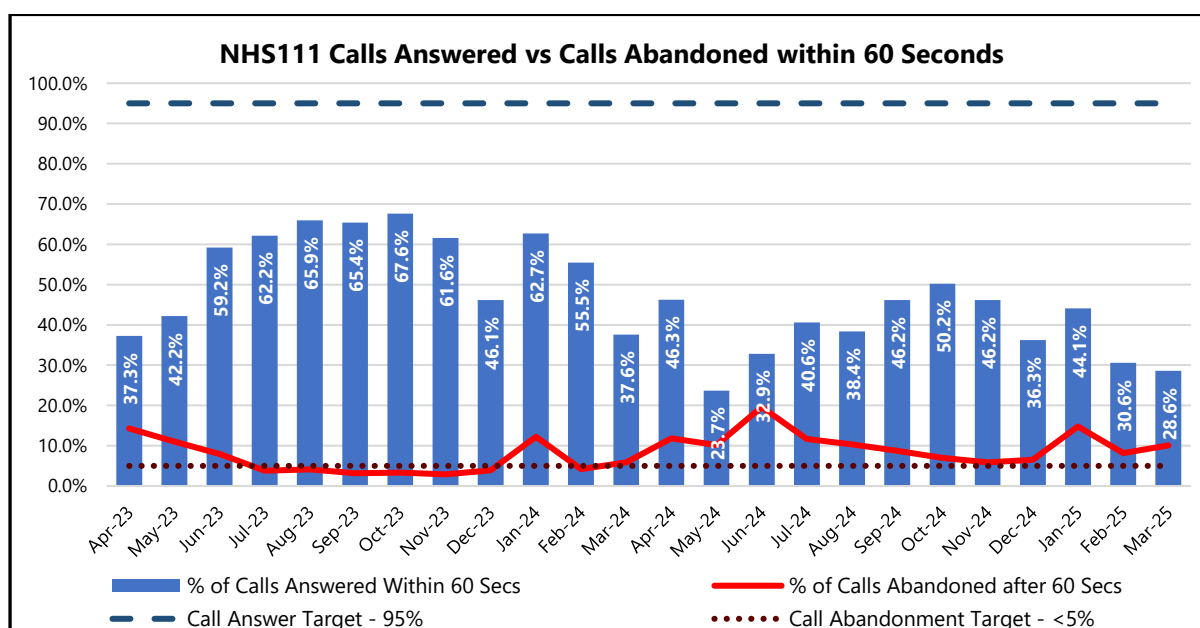


1.7.1 Our Patients – Quality, Safety and Patient Experience

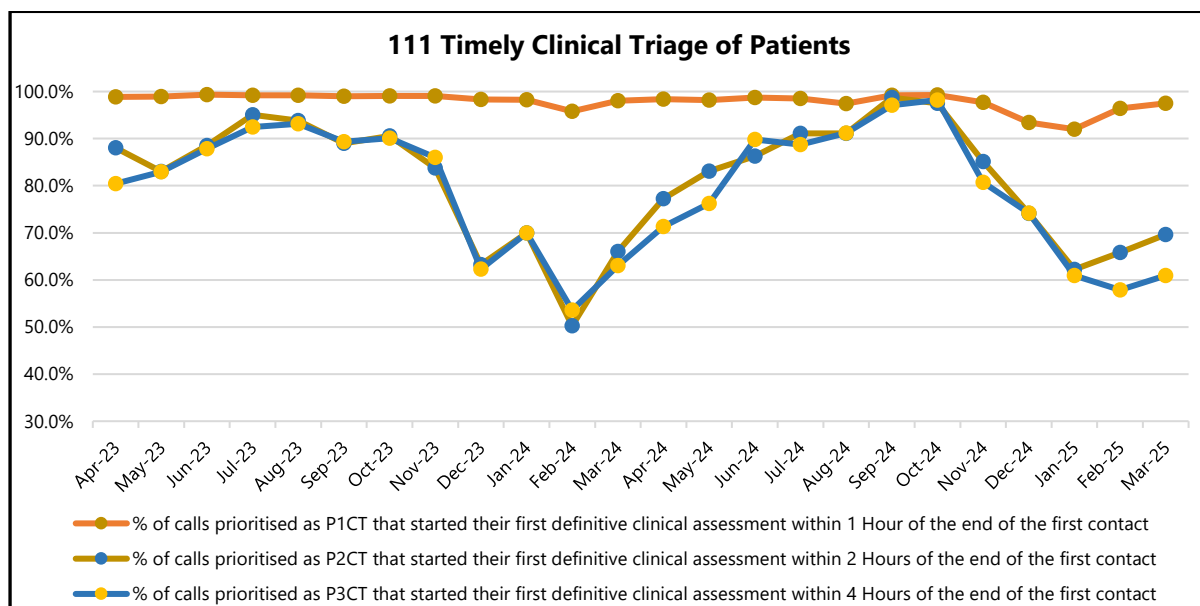
NHS111 Wales Service

For many of the Trust's patients, the first point of contact with the Trust is the **111 service**, which has been live across the whole of Wales since early 2022. Over the past year the number of calls received into the 111 service has increased, rising from 970,684 111 calls in 2023/24 to 1,002,211 calls in 2024/25.

The Trust measures the quality of the service it provides through call answering times, abandonment rates and clinical ring back times. Performance within this area saw a drop off during early 2024/25, primarily due to the implementation of the new 111CAS system, which went live on 30 April 2024. In the run up to this implementation staff were abstracted for training and in addition recruitment was paused. Following 'go live' staff were familiarising themselves with the system, which had a further impact on efficiency. Although performance did start to improve from June 2024, winter pressures and high levels of sickness absence in December 2024 did have a further impact.



The graph above shows that only 38.8% of calls were answered within the 60 second target during 2024/25, compared to 54.8% in 2023/24. Abandonment rates increased from an average of 6.6% in 2023/24 to 10.4% during 2024/25, with the 5% target not being achieved in any of the 12 months.



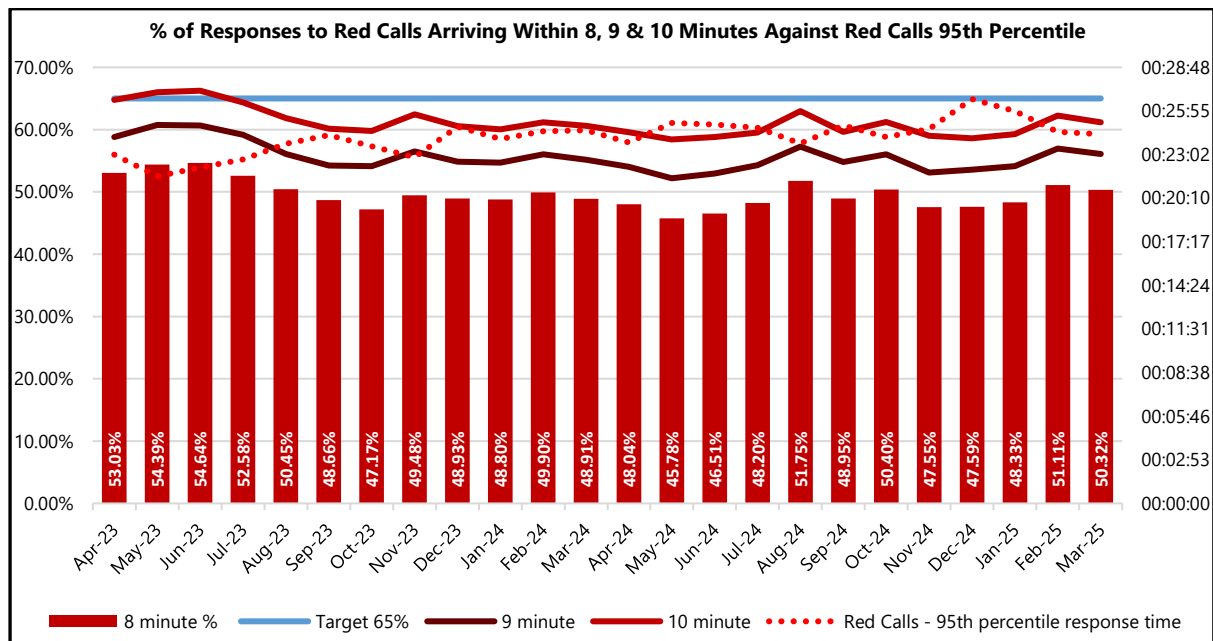
In relation to clinical ring back for triage, the Trust consistently achieved the one-hour target of 90% for highest priority patients (Priority 1 Clinical Triage – P1CT), averaging 95.6% during 2024/25. Performance for lower priority calls, after achieving the 90% target between August and October 2024, deteriorated in the second half of the year, falling to around 60% in January 2025. For the year this meant, that on average, 81.6% of patients prioritised as Priority 2 Clinical Triage (P2CT) received a clinical ring back within two hours of the end of the first contact and 78.9% of patients prioritised as Priority 3 Clinical Triage (P3CT) received a clinical ring back within 4 hours of the end of the first contact.

Emergency Medical Services (999 calls)

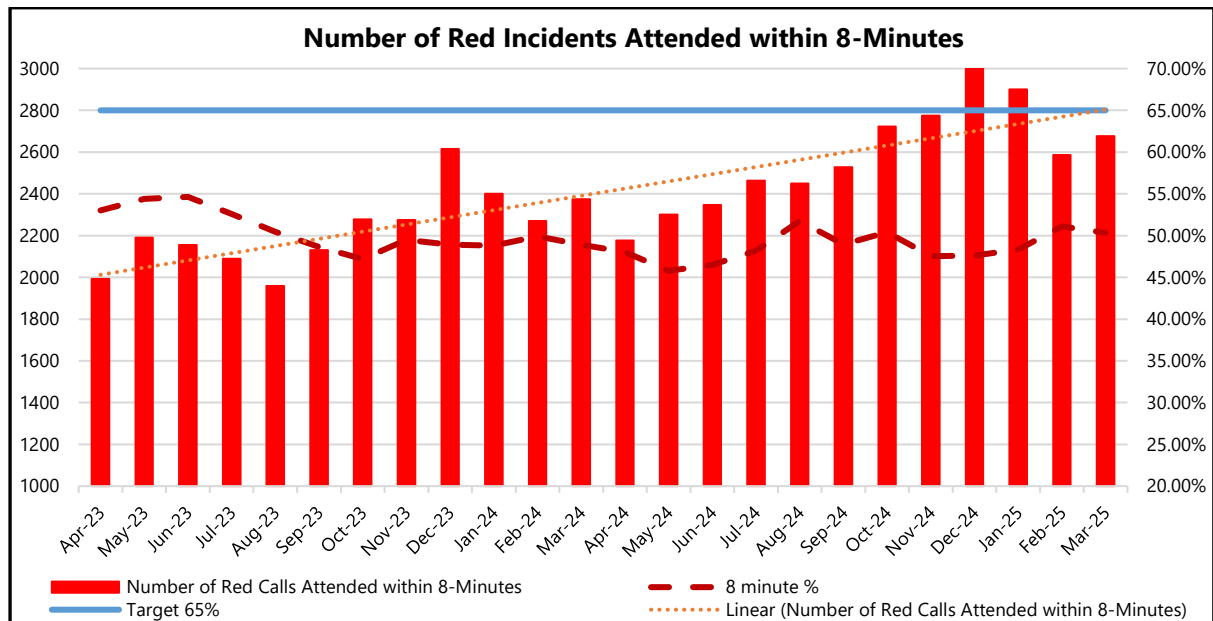
Within the EMS, despite the actions taken through the year, the ongoing system pressures, in particular, excessive hospital handover delays, have led to continued unacceptably long waiting times for an ambulance which in turn have contributed directly to avoidable patient harm.

Harm can occur to patients who have waited too long for a response in the community, to those who are waiting in the back of an ambulance for handover into an emergency department (ED), or to those who we cannot send an ambulance to at times of highest escalation. The Trust Board receives a detailed report at each of its meetings on actions being taken to reduce and mitigate this avoidable harm.

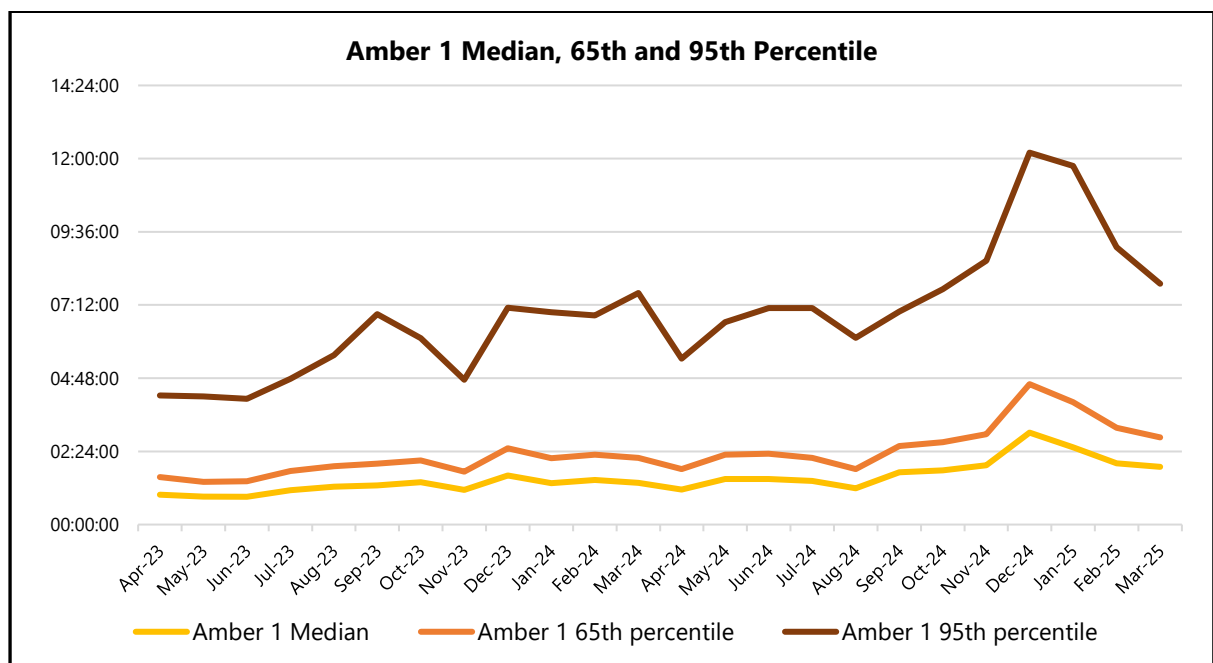
The Welsh Government target for 2024/25 was to respond to 65% of immediately life threatening 999 calls (Red calls) within eight minutes. Despite slight seasonal increases in performance, the Trust has seen no clear long term improvement against this target over the past year, with the average for the year of 48.7% being a marginal decline from the 50.4% seen during 2023/24.

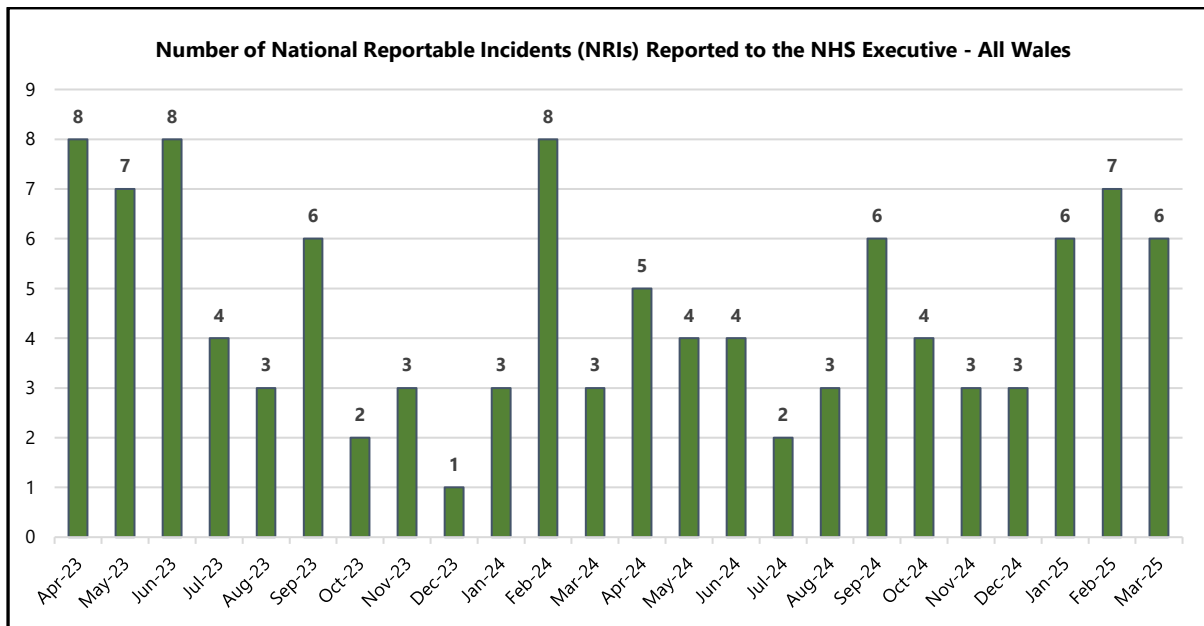


However, there has been a clear increase in the volume of Red incidents attended within eight minutes, as can be seen in the graph below. In 2022/23 the Trust was attending an average of 1,966 Red incidents per month; during 2023/24 this figure rose to 2,227, and during 2024/25 this figure increased again to 2,591. This would indicate an improvement in overall performance, but due to a significant rise in the number of verified Red incidents over the past year (20.5% increase) this has not been replicated within the Red eight percentage figures.



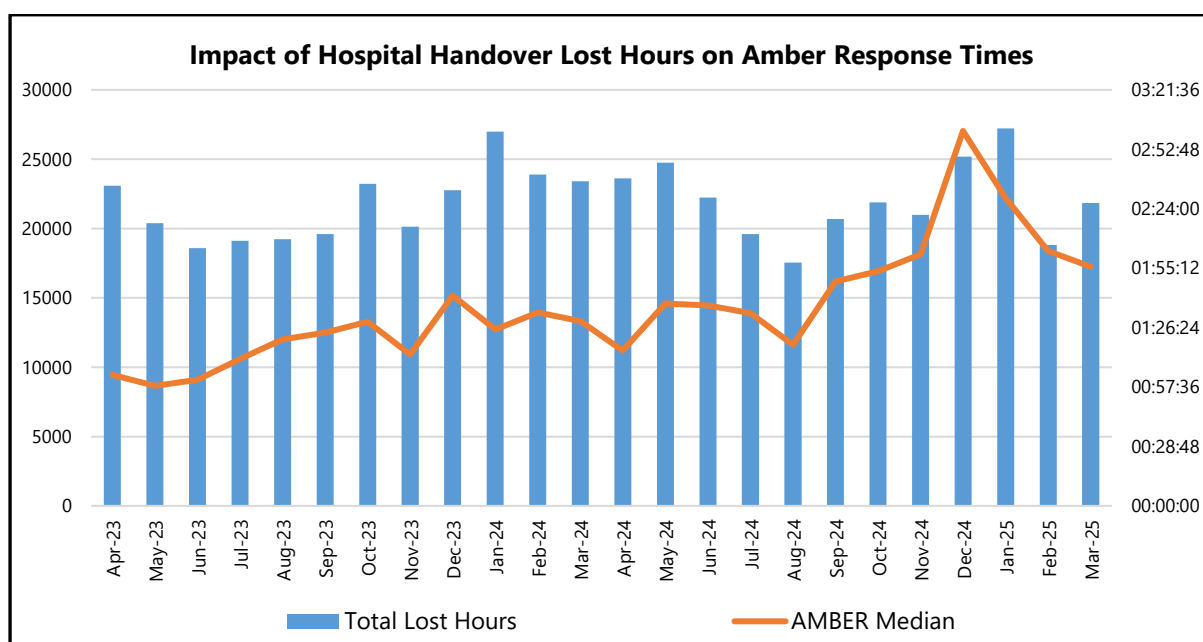
For patients in our Amber 1 category (serious but not immediately life threatening), there is no specific target set for response times, but with calls including those for stroke and cardiac arrest, the Trust would ideally want to respond on average within 18-minutes. The Amber 1 average monthly response time during 2024/25 was 1 hour 41 minutes.





In relation to the most serious incidents, the Trust reported 53 patient National Reportable Incidents (NRIs) in 2024/25 compared with 56 in 2023/24. Most, but not all, of these NRIs relate to the Trust's 999 service. The number of incidents reviewed at the Significant Clinical Incident Forum (SCIF) reported to the Health Boards under the Joint Investigation Framework fell slightly, from 173 in 2023/24 to 166 in 2024/25, although an increase was seen in the last quarter of 2024/25. These are often due to long waits in the community caused by handover delays at hospitals.

There are many reasons for longer response times, which include increases in Red call demand and overall acuity, a loss of capacity through above benchmark abstractions (achieving benchmark by end of year) and extreme hospital handover delays. There is a clear correlation between the latter of these factors and higher response times, particularly when considering Amber incident responses, as can be seen in the graph below.

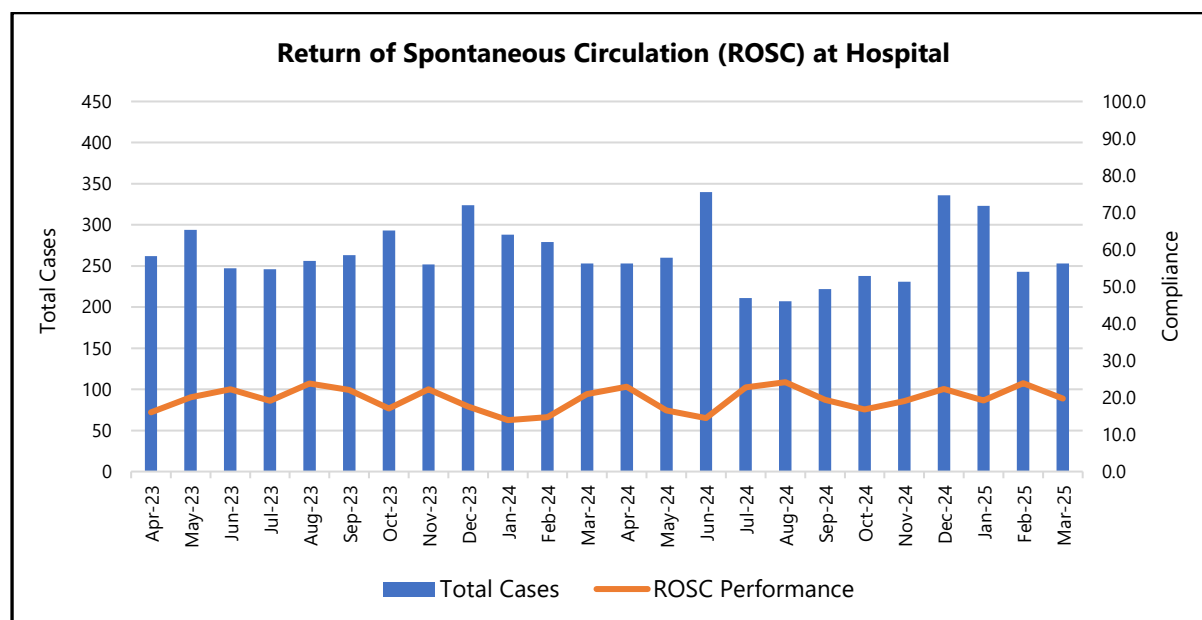


Over the past year the Trust has undertaken a number of initiatives to positively impact upon response times and the quality of the service it provides. These include:

- Recruitment: with 95% of commissioned front-line posts now in place.
- The continued implementation of the CHARU which the Trust has now grown to 122.5 FTE; just 18 short of its 140.5 FTE pan-Wales target.
- The Managing Attendance Programme continues to be delivered through the ten-point plan, with a reduction in overall sickness levels during 2024. Work is on-going with the aim to reduce to 6%.
- The implementation of Rapid Clinical Screening.

Significantly improved performance is still dependent on handover delays at hospitals reducing in line with Ministerial expectations, which currently is not the case. The Trust also measures and monitors five clinical indicators, these being Fractured Neck of Femur, Stroke, ST Elevation Myocardial Infarction (STEMI), Hypoglycaemia and Return of Spontaneous Circulation (ROSC). Introduced through 2022, the electronic Patient Clinical Record (ePCR) is now fully embedded within the Trust and has significantly enhanced the collection and sharing of clinical information. As anticipated, this has led to improvements in the completeness and accuracy of clinical data capture, supporting more robust reporting on the five key clinical indicators.

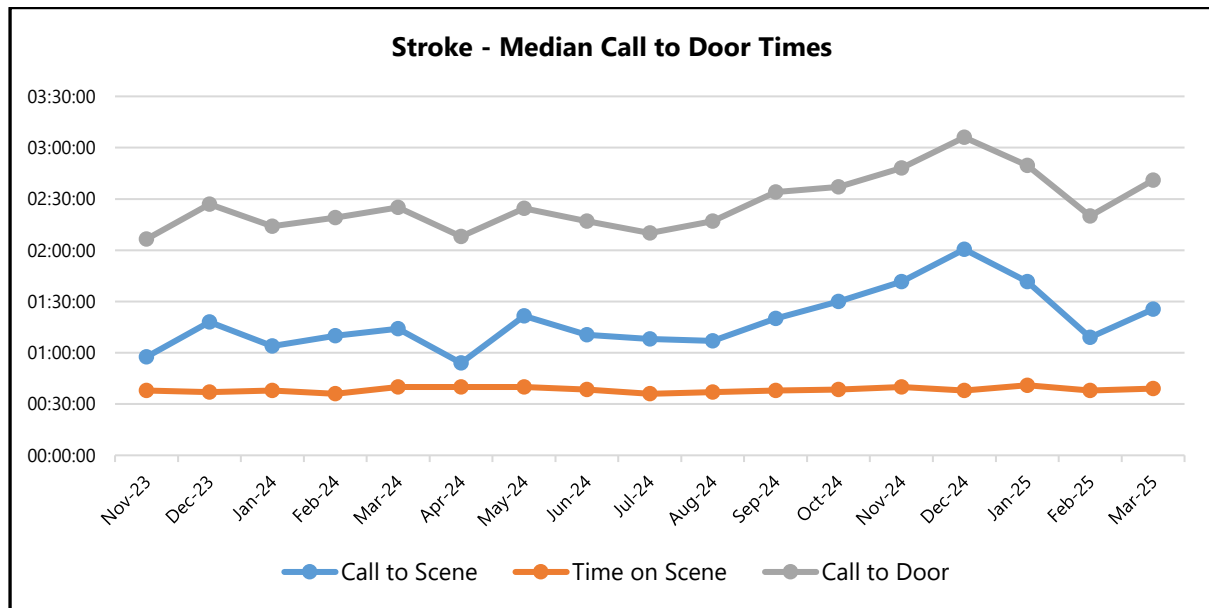
The graph below shows, the number of patients who had ROSC at hospital for the year 2024/25. Although this metric remains lower than the Trust would want, it does show a gradual improvement on 2023/24.



Of the other key clinical indicators, the Trust measures none of them achieved the 95% target during 2024/25, although there were some significant improvements in performance seen in many areas.

There were also improvements seen in the percentage of older people with suspected hip fracture who are documented as receiving the appropriate care bundle; the percentage of STEMI patients who are documented as receiving the appropriate care bundle; the percentage of hypoglycaemic patients who are documented as receiving the appropriate care bundle, and the percentage of suspected stroke patients who are documented as receiving the appropriate care bundle, with the figure for March 2025 of 91.6% being an improvement on the 72.8% reported for March 2024.

The Trust also now reports on the call to door times for both Stroke and STEMI patients, which encapsulates the total time from the call being received to the patient arriving at hospital. As the graph below for Stroke patients shows, these have deteriorated slightly during 2024/25, averaging two hours 31 minutes compared to two hours 10 minutes in 2023/24.

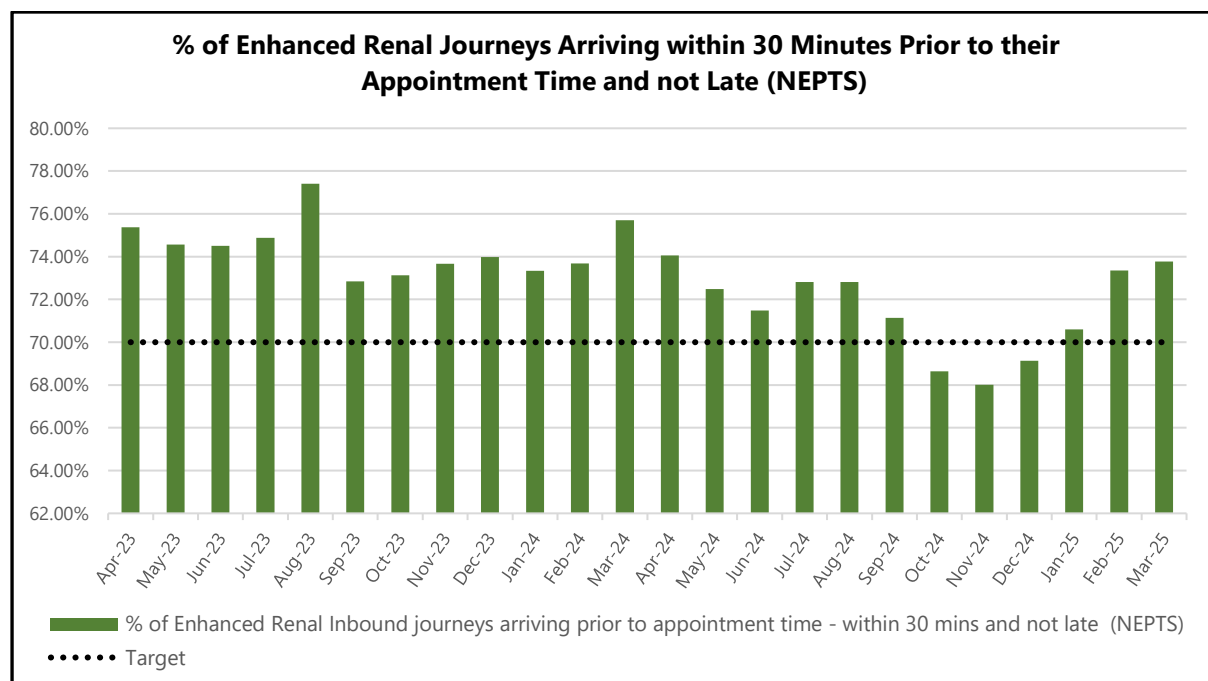


The Trust continues to develop the CHARU, which has been introduced to directly impact upon the ROSC metric. This service is aimed at providing an on scene clinical leadership for high acuity incidents by an experienced paramedic with additional medicines and training. They support clinical decision making, co-ordinate patient care and ensure clinical practice is in line with current best practice guidelines to improve overall outcomes.



Ambulance Care

In relation to the Trust's **Ambulance Care** service, which includes NEPTS, demand is still not quite back to pre-Covid-19 levels; but the complexity of the service has increased following reconfigurations by Health Boards of planned care systems increasing distance and complexity of journeys. There is still a high level of uncertainty around demand as Health Boards continue to move through service changes, including further weekend clinics. A national roster review is currently underway which is a highly complex piece of work, and which has the potential to improve efficiency; but will be challenging to deliver. This is a high-volume service, with over 567,000 patient journeys across the year.



The quality of the service for patients is measured through metrics which consider whether patients are transported to and from their hospital appointments in a timely manner and new performance standards were introduced in April 2023. Targets are met for most patients, with an average of 71% of renal journeys and an average of 78% advanced booked transfer and discharge journeys being completed within the required timeframes. Patient survey data is positive, with satisfaction rates increasing to 87.3% by the end of the year.

Quality Management

The Trust has a 75% target for responding to patient concerns within 30 days, although this remains challenging and has not been achieved in any month during the past two years. In March 2025 compliance was 55% for responding to patient and family concerns within the 30 day period.

A multi-disciplinary panel meets regularly to review incidents to ensure appropriate investigations are undertaken. Joint investigations with Health Board colleagues are undertaken to ensure improvements cover the whole of the patient pathway. The Quality Governance arrangements are discussed in more detail in the Accountability Report.

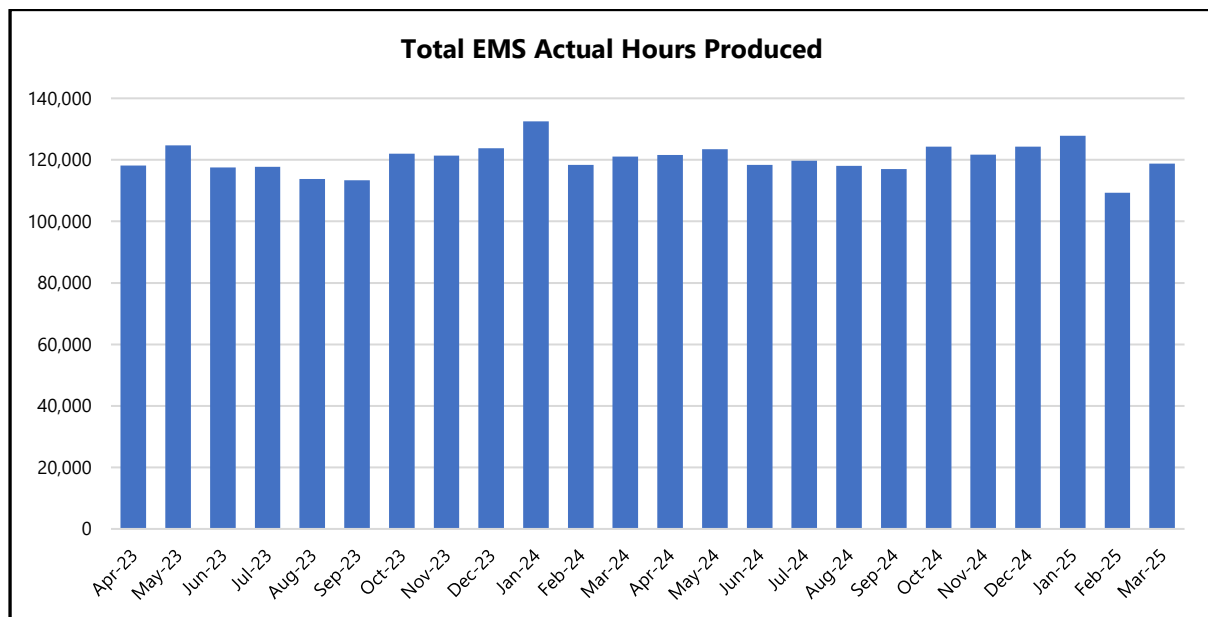
The Patient Experience and Community Involvement (PECI) Team continues to engage with the public to listen, capture and report on their experiences of accessing and receiving care across all Trust services. The feedback captured and reported demonstrates how patient experience is a key indicator of the level of quality being provided and the need to improve patient experiences, patient safety, and patient outcomes.

1.7.2 Our People

In relation to the Trust's workforce, the indicators reviewed at Board relate to whether the Trust has the right workforce capacity in place to meet demand, how the Trust is keeping staff safe and well, and how they are being developed. More detailed and numerous indicators are also considered at the People and Culture Committee (PCC).

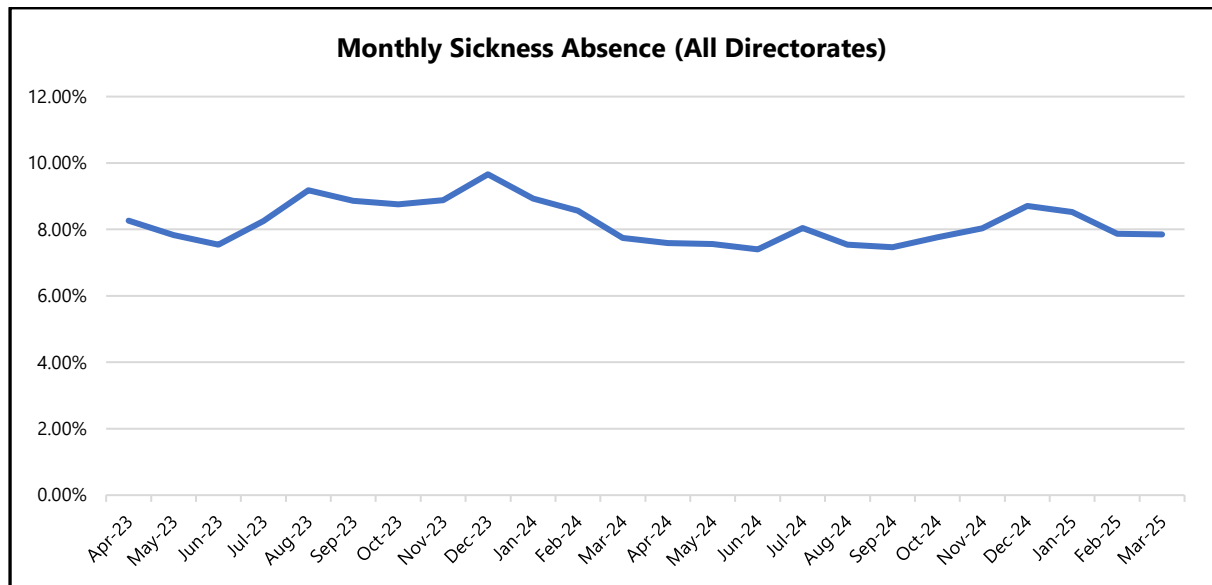
The Trust had a budgeted establishment of 1,823 FTEs for EMS in 2023/24. This establishment increased to 1,904 FTEs in 2024/25. This reflects the Trust's commitment to growing roles such as CHARU and APP in EMS which have seen a considerable rise in the planned establishment. CHARU numbers increased to 122.5 FTEs during 2024/25, while APP establishment grew from 88.5 to 112.9 (24.4 FTE growth). The majority of these APPs are currently undertaking their MSc course in Advanced Practice, and we are expecting to see the benefit of this recruitment in quarter two of 2025/26.

The graph below demonstrates the number of EMS ambulance unit hours it is able to produce in 2024/25 compared to the previous year and highlights it has remained stable. In 2024/25, 1,444,419 actual hours were produced compared to 1,444,431 hours in 2023/24. These hours are a significant uplift in the number of EMS hours produced compared with years prior to 2023; but this gain has been subsumed by the continued high number of hours lost to handovers at hospital.

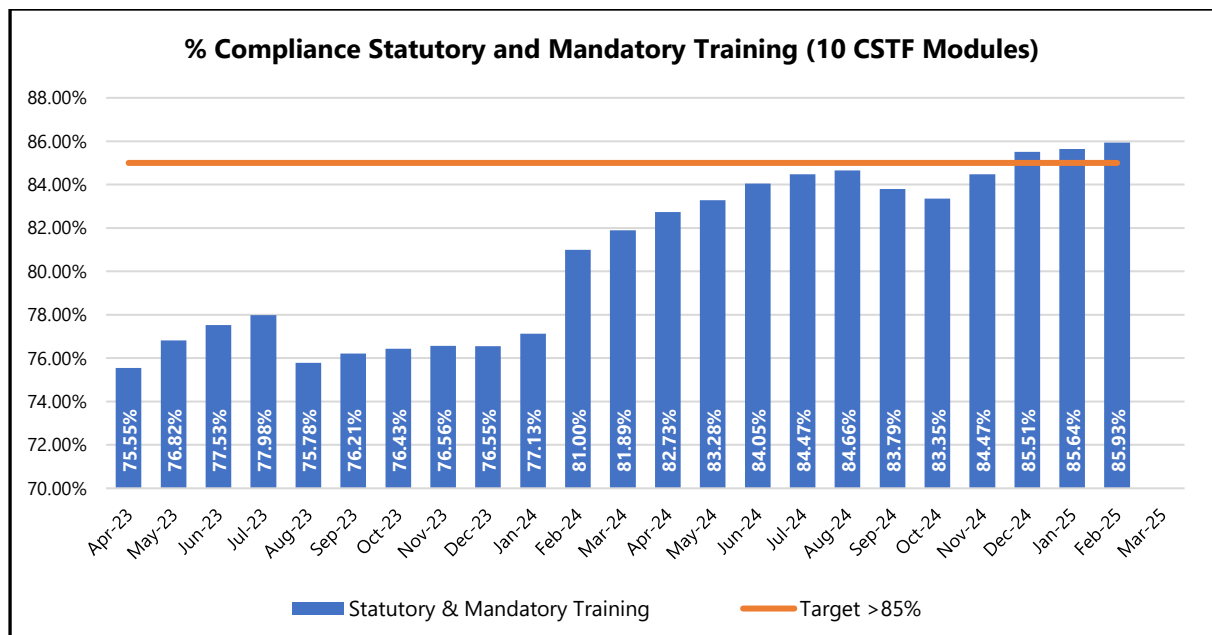


Another key factor in the Trust's ability to ensure capacity to meet the demand is the impact of roster abstractions, and this also provides an indicator of our people's well-being. To support the workforce there has been an ongoing focus on well-being activities across all areas of the Trust, including those in both frontline and support roles.

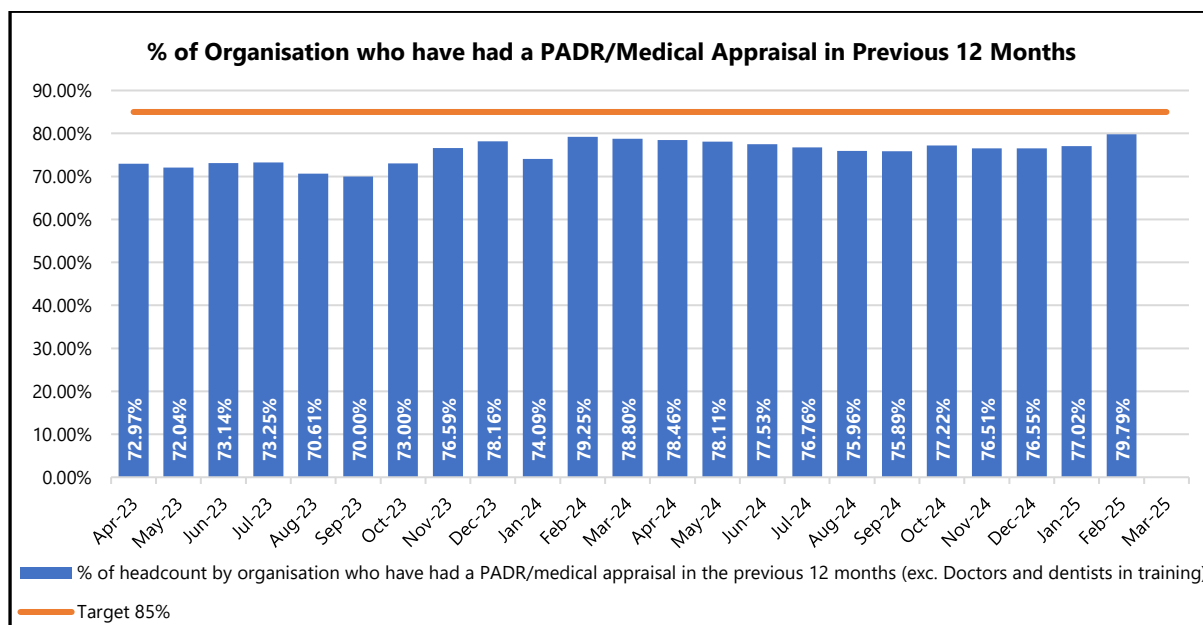
Despite this, sickness has remained one of the key causes for rota abstraction, although the graph below shows that positive progress has been made over the past year, with the year-end figure for 2025 of 7.82% being lower than the 8.54% seen in March 2024. This is despite ongoing system pressures, outside of the Trust's control, which have a negative impact upon staff wellbeing.



Statutory and Mandatory Training rates achieved the 85% target overall at year end, recording over this rate for the last four months of the year. This follows a gradual improvement seen since January 2024. This is demonstrated in the below graph:

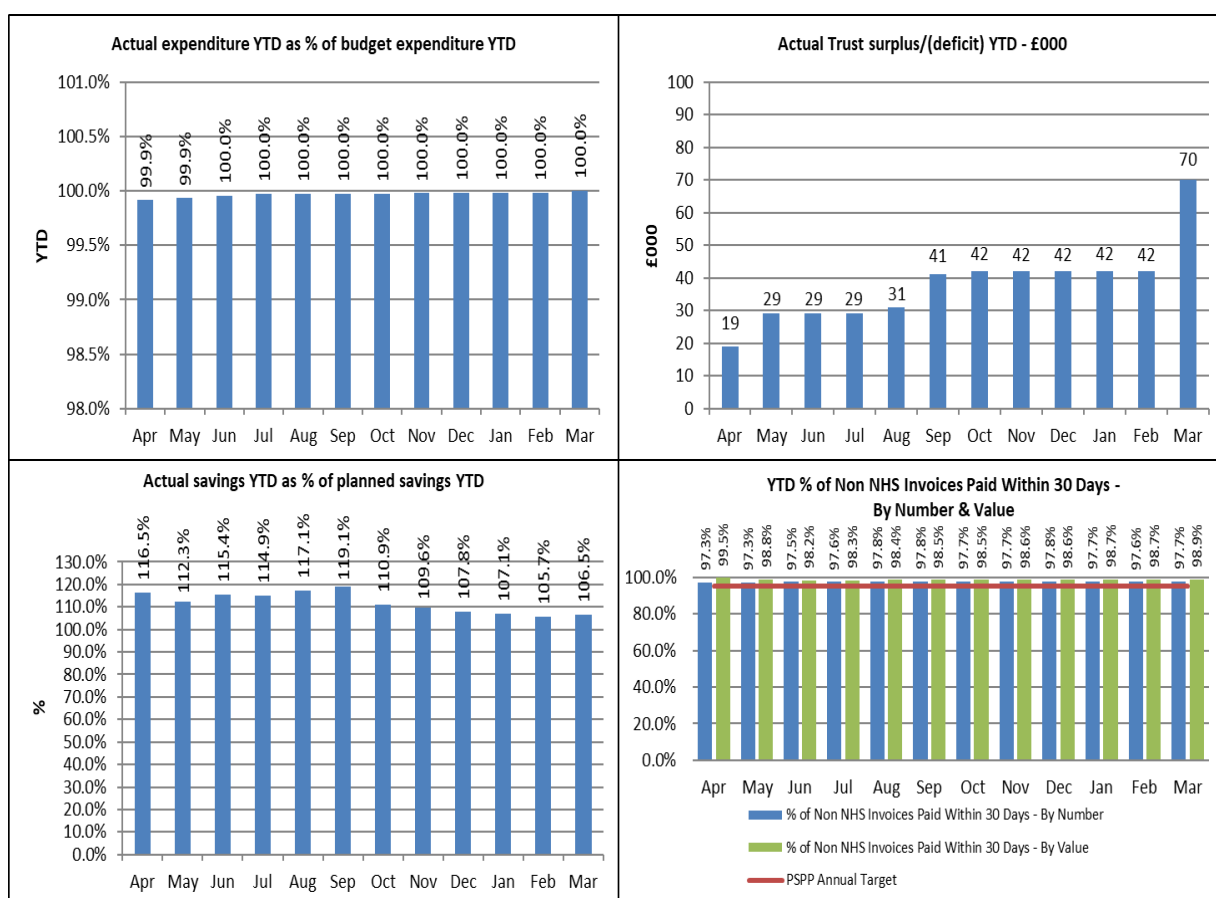


In terms of staff development, the Trust views levels of Personal Appraisal and Development Reviews (PADR) as the best way of representing development at a high level. Although the year end figure for 2024/25 of 79.8% failed to achieve the 85% target, it has shown a sustained gradual improvement over the past two years.



1.7.3 Finance and Value

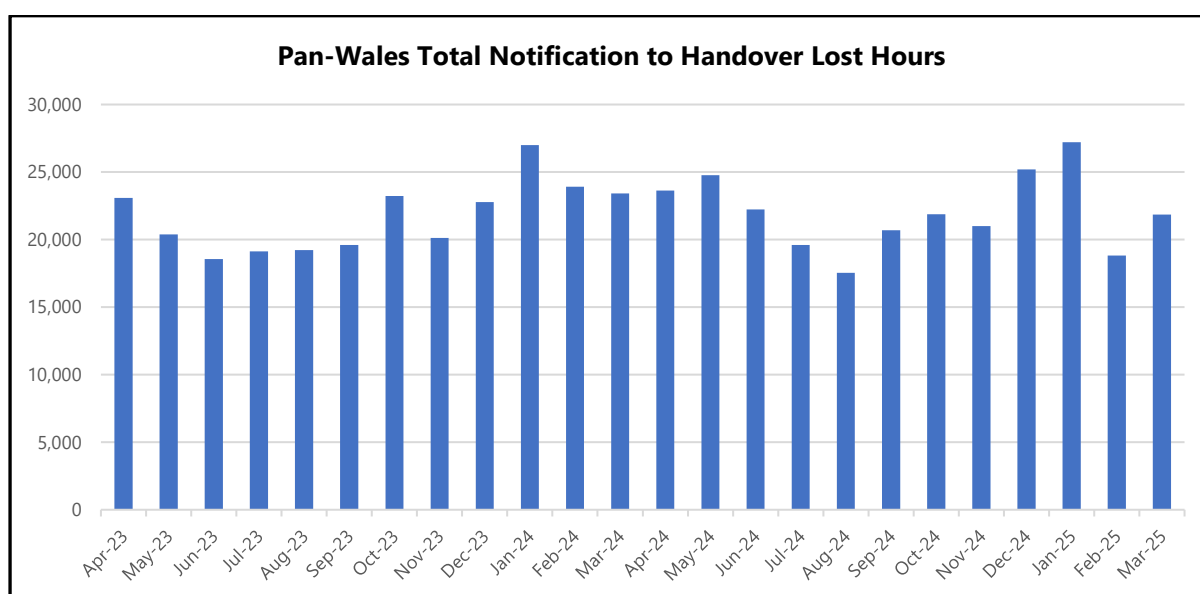
The Trust reviews a number of indicators which aim to demonstrate how it provides a service in line with statutory financial duties, and of high value and efficiency. This area of the Performance Report will be strengthened over time as the value-based health care programme continues. The Trust achieved financial balance in 2024/25, with a small revenue surplus of £70,000 alongside delivering capital expenditure within its Welsh Government set Capital Expenditure Limit, thereby meeting its statutory duty to breakeven during this financial year.



Gross savings of £6.838m were achieved against a target of £6.421m, thus an over achievement of c.6.5%. The Public Sector Payment Policy was on track with performance of 97.7% for the number, and 98.9% of the value of non-NHS invoices paid within 30 days (target 95%). Further information can be found in the Trust's annual accounts and financial statements, which have been prepared on a going concern basis.

1.7.4 Partnerships and Systems Contributions

The Trust aims to consider both its impact on the wider system, but also the wider system's impact on its service. Although handover lost hours reduced in 2023/24 compared to 2022/23, they have risen again over the past year, averaging 22,003 hours per month during 2024/25 compared to 21,700 a month in 2023/24. This figure remains extreme and equates to 1,834 twelve-hour shifts and meant the Trust could have responded to over 3,454 more patients each month if handovers were reduced. The total ambulance hours lost during 2024/25 was 264,393, meaning the Trust is losing between a quarter and a third of its conveying ambulance production.

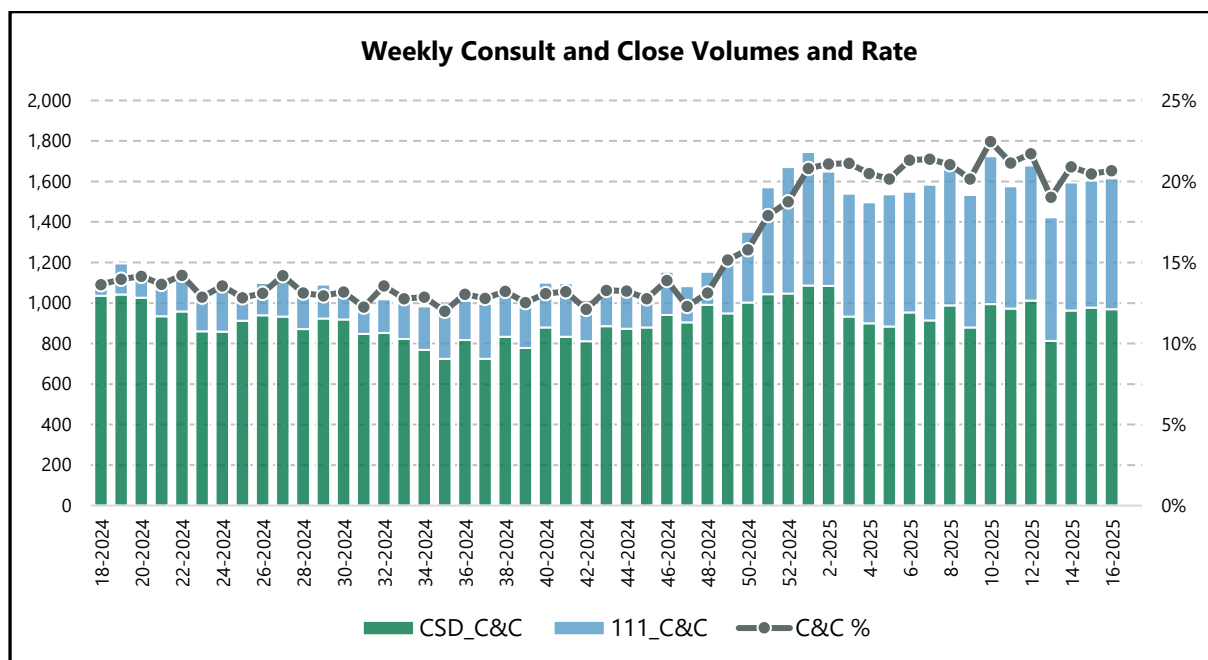


The Trust is aware that Health Boards introduced urgent and emergency care escalation frameworks during 2024 to try and reduce lost hours to handover, following strong messaging from Welsh Government and the Cabinet Secretary for Health and Social Care that this issue must be tackled as a matter of priority.

Although overall levels throughout the year did increase, there were some positive signs in February and March 2025, with both months showing significant reductions on the same period last year. Although early days, this may be due in part to the reduction in the number of conveyances seen into EDs since the introduction of the Remote Clinical Screening process, as part of the CMT programme.

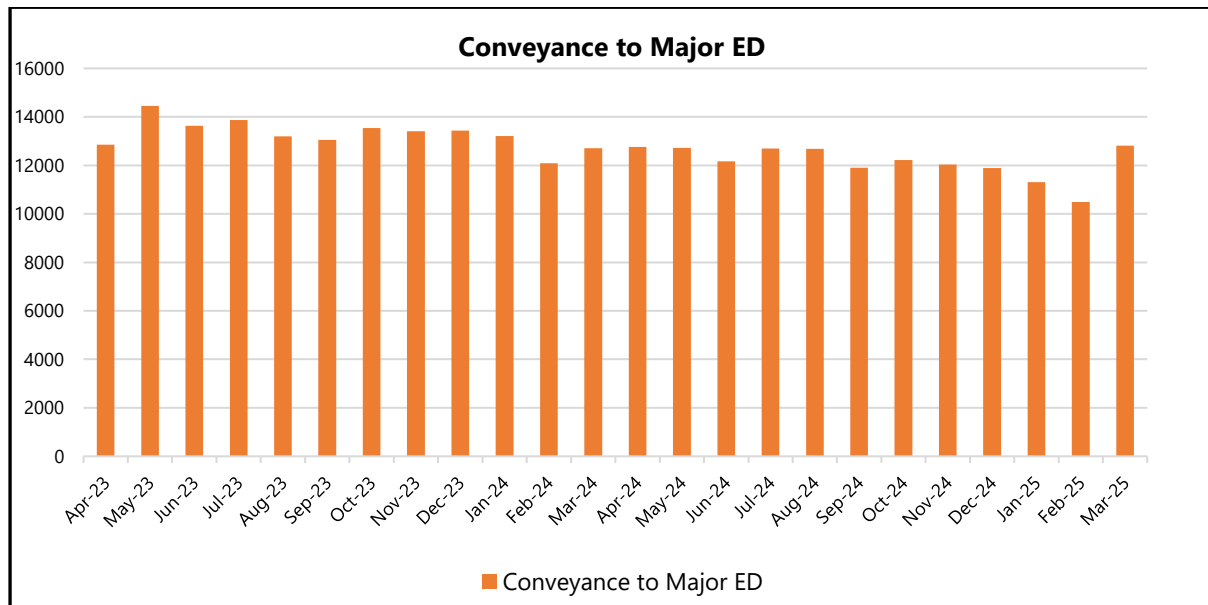
The Trust is committed to transforming its services to become more sustainable, to get patients to the right service, in the right place, every time, and to reduce the reliance on emergency departments as the default location for definitive urgent and emergency care, something which is at the forefront of the new CMT programme.

One of the key areas where the Trust already supported the system in reducing demand is 'Consult and Close' through the work of the CSD and 111. The 2024/25 'Consult and Close' WG target was set at 17%. There have been some issues with collecting data on this metric from October 2024, due to responding to the new NHS 111 Wales system and interpreting data to correctly identify incidents that originate via 999. However, following more robust reporting, recent data suggests that the figure over the past 4 months has averaged around 20%, as indicated in the graph below.



The Trust's focus is to treat more patients through 'Consult and Close', 'See and Treat' and pathways, therefore avoiding the need for a conveyance to an ED. 'See and Treat' rates and those treated at scene have increased slightly against responded incidents year on year, rising from a monthly average of 17.1% in 2023/24 to 17.8% in 2024/25.

The number of conveyances to a major ED has decreased over the past year, from 159,472 in 2023/24 to 145,698 in 2024/25. This is also over a period when the number of Red incidents, where the patient has been seriously ill, increased by 20.4%.



Another key component of the Trust's long-term strategy is that more paramedics than ever before are being supported to undertake further education to become APPs, with evidence showing that the additional knowledge and skills reduce rates of conveyance to hospital. During 2024/25 APP establishment grew from 88.5 to 112.9 (24.4 FTE growth).

The Trust is now a member of all seven Regional Partnership Boards (RPB), or a substructure thereof in the case of Gwent, in Wales. This means that the service now has a voice at these strategic decision-making fora, with other statutory partners, community partners and the third sector; which further aids the delivery of the service's long term strategy.

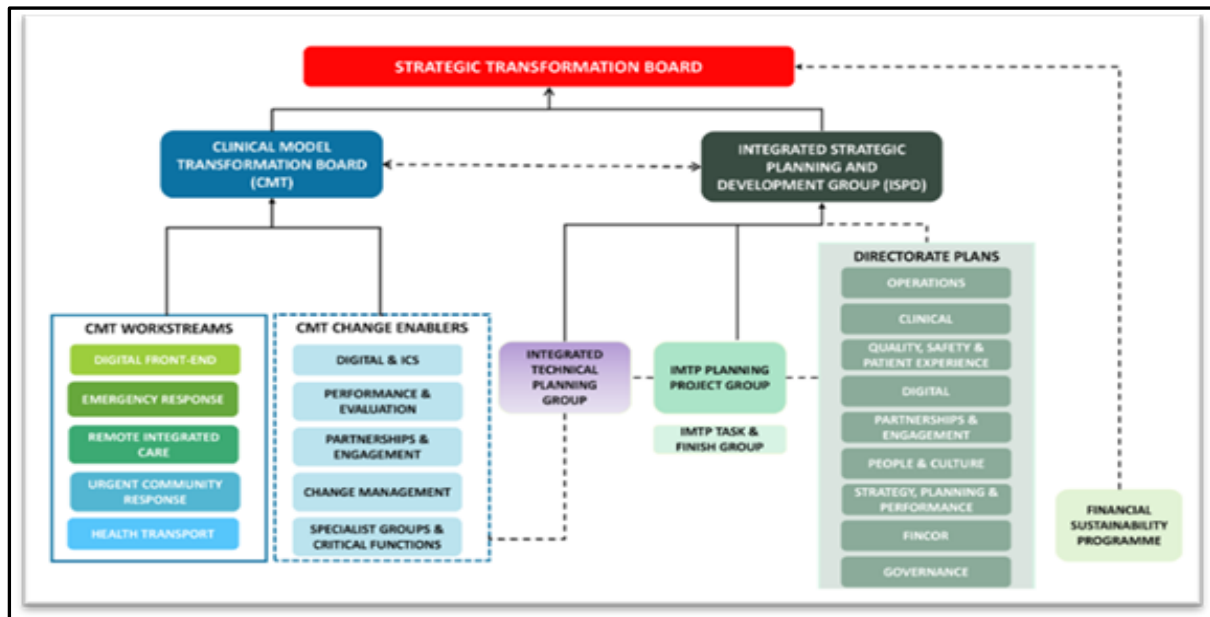
The Trust is represented at these fora by the Director of Partnerships and Engagement, who is also currently the Vice-Chair of the North Wales Regional Partnership Board, and the Executive Director of Strategy, Planning and Performance. Membership of these fora helps the Trust with its engagement, influencing and understanding of common challenges and opportunities, but also has tangible benefits, for example, in providing access to alternative funding flows, such as the Regional Integration Fund (RIF).

While the Trust had hoped to fall under the auspices of the Wellbeing of Future Generations Act 2015 in 2023/24, this was delayed and was instituted from 30 June 2024. During the year, however, the Trust continued to work within the spirit of the Act, which include the development and publication of its wellbeing objectives which were approved by the Trust Board in March 2025. The objectives set by the Trust can be viewed on the Trust website: [Our Wellbeing Objectives: Focused on the Future](#).

The Trust has refreshed its engagement framework and delivery plan. The framework and a planned focus on working with stakeholders and the public on new solutions for the Trust as an ambulance service, while making a positive impact on the wider health and care system. A programme of positive engagement with our stakeholders, patients and the public will continue in 2025/26 on how the Trust can ensure its services better meet the needs of the people it serves going forward.

1.7.5 Integrated Medium-Term Plan (IMTP) Delivery

The IMTP delivery structure was reviewed in 2024, and previous transformation programmes were brought under the umbrella of a single CMT Programme with wider IMTP actions delivered through Directorate plans. Both the CMT and Directorate led IMTP programmes of work report to the STB.



The STB continued to meet regularly (every six weeks) during the year, delivering significant transformation despite the increased operational and financial pressure across NHS Wales across the urgent and emergency care system. The infographic overleaf shows some of the delivery across the breadth of the IMTP throughout 2024/25.

Good progress was made in all areas, including in areas such as digital, estates and fleet. There were some areas that we were not able to achieve, including continued delay to the re-rosters in NEPTS and a demand and capacity review in 111. However, these have now progressed with delivery expected in 2024/5. The development of the 111 website and updated symptom checkers remain a priority but could not be delivered in 2024/25 as funding has not yet been agreed. Key deliverables in 2024/25, however, were the implementation of the new 111 system in April 2024 which paved the way for some important changes to the Trust is going to make through the CMT programme, and the implementation of Rapid Clinical Screening of 999 calls.

1.7.6 Managing Risk

There is a detailed narrative on the Trust's capacity to handle risk within the 'Capacity to Handle Risk' section of the Annual Governance Statement, within the Accountability Report.

DELIVERY AND PERFORMANCE ANALYSIS

The Delivery and Performance Analysis section provides commentary on the Trust's key performance measures and a more detailed integrated performance analysis of the Trust's service delivery.

1.8 Our Patients (Quality, Safety and Patient Experience)

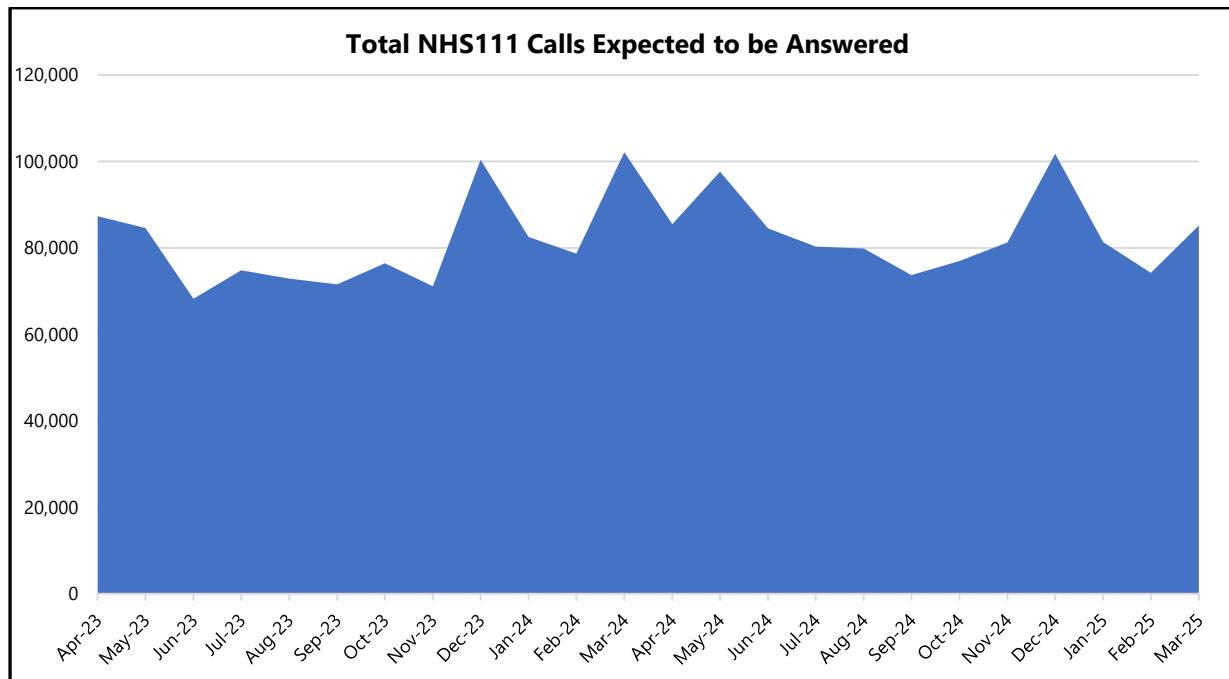
Call Answering

For many of the Trust's patients, the first point of contact with the Trust is the **111 service**, which has been live across the whole of Wales since early 2022.

Performance within this area saw a drop off during early 2024/25, primarily due to the implementation of the new 111CAS system, which went live on 30 April 2024. In the run up to this implementation staff were abstracted for training and in addition recruitment was paused.

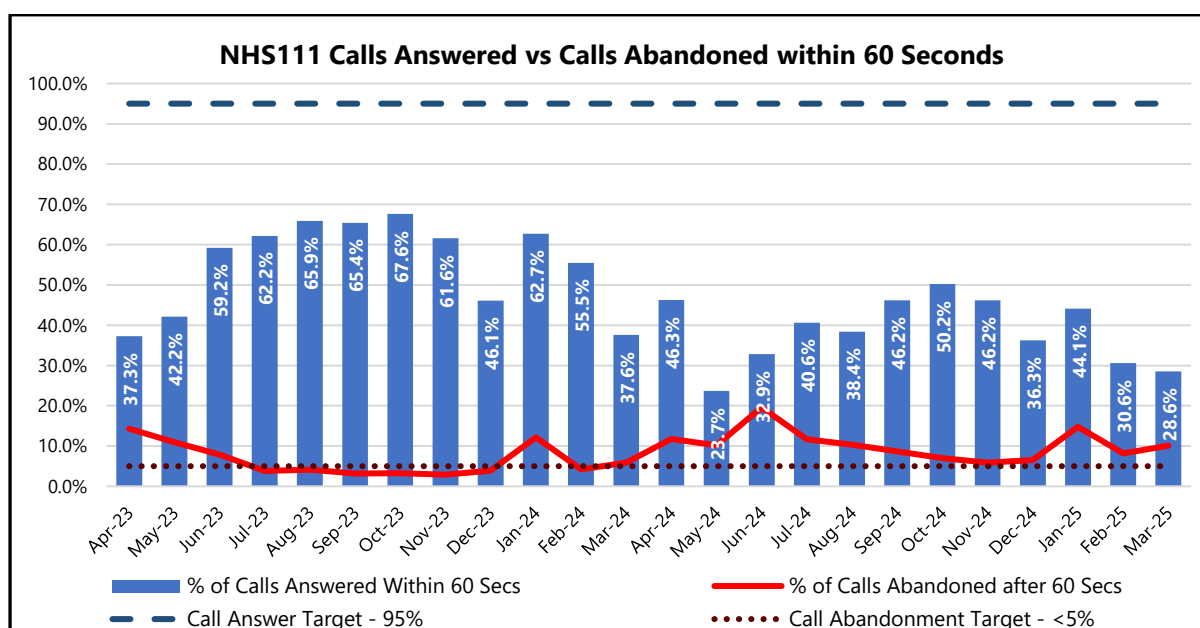
Following 'go live' staff were familiarising themselves with the system, which had a further impact on efficiency. Although performance did start to improve from June 2024, Winter pressures and high levels of sickness absence in December 2024 did have a further impact.

Over the past year the number of calls received into the 111 service has increased, rising from 970,684 111 calls in 2023/24 to 1,002,211 calls in 2024/25.

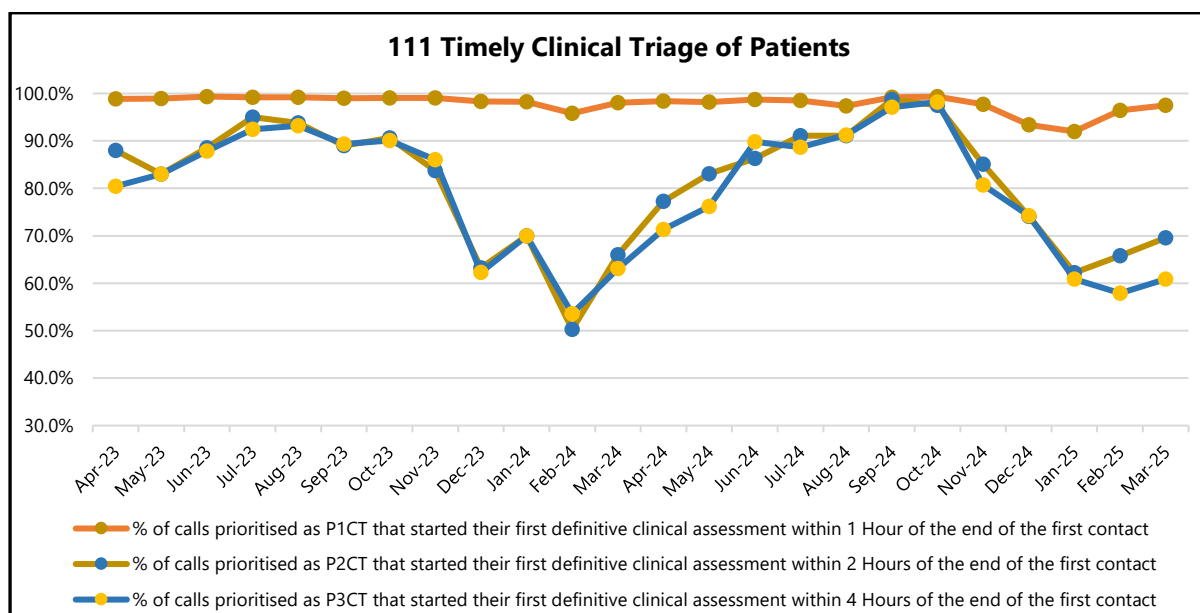


In the **111 service**, the Trust measures the quality of the service it provides through call answering times and clinical ring back times. The Trust aims to answer 95% of calls within 60 seconds and to have an abandonment rate of less than 5%, illustrated in the graph below.

The graph below highlights a drop off in performance during 2024/25, for reasons alluded to in the paragraph above. It shows that 38.8% of calls were answered within the 60 second target during 2024/25, compared to 54.8% in 2023/24. Abandonment rates also declined, increasing from an average of 6.6% in 2023/24 to 10.4% during 2024/25, with the 5% target not being achieved in any of the 12 months. However, the Trust has now implemented a virtual queueing system, so a caller can elect to hold their position within the queue and be rung back rather than have to wait on the line.

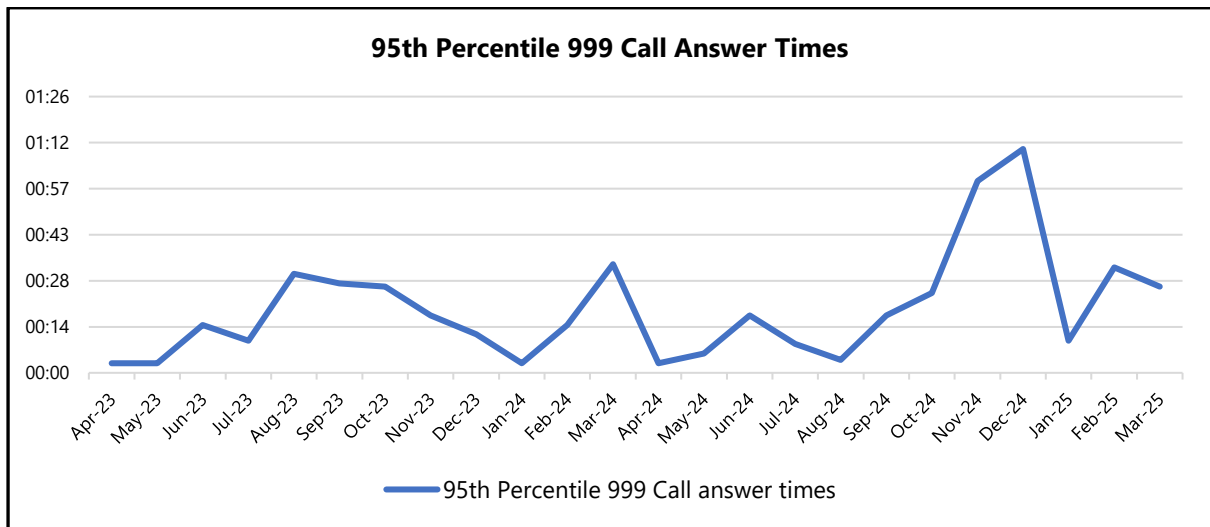


In relation to clinical ring back for triage, the Trust consistently achieved the one-hour target of 90% for highest priority patients (Priority 1 Clinical Triage – P1CT), averaging 95.6% during 2024/25. Performance for lower priority calls, after achieving the 90% target between August and October 2024, deteriorated in the second half of the year, falling to around 60% in January 2025. For the year this meant, that on average, 81.6% of patients prioritised as Priority 2 Clinical Triage (P2CT) received a clinical ring back within two hours of the end of the first contact and 78.9% of patients prioritised as Priority 3 Clinical Triage (P3CT) received a clinical ring back within four hours of the end of the first contact.



Patients have provided feedback on long wait times and there is potential for these waits to have a knock-on effect on both 999 and the rest of the urgent and emergency care system. The Trust is acutely aware that improved performance in this area is closely linked to having the correct number of clinicians in post to meet the current and expected demand, which forms a part of the 111 roster practice review being undertaken in early 2025/26. Performance in this area has also been affected by a high level of clinician sickness absence, especially long-term absences. Actions are also being taken to improve this position.

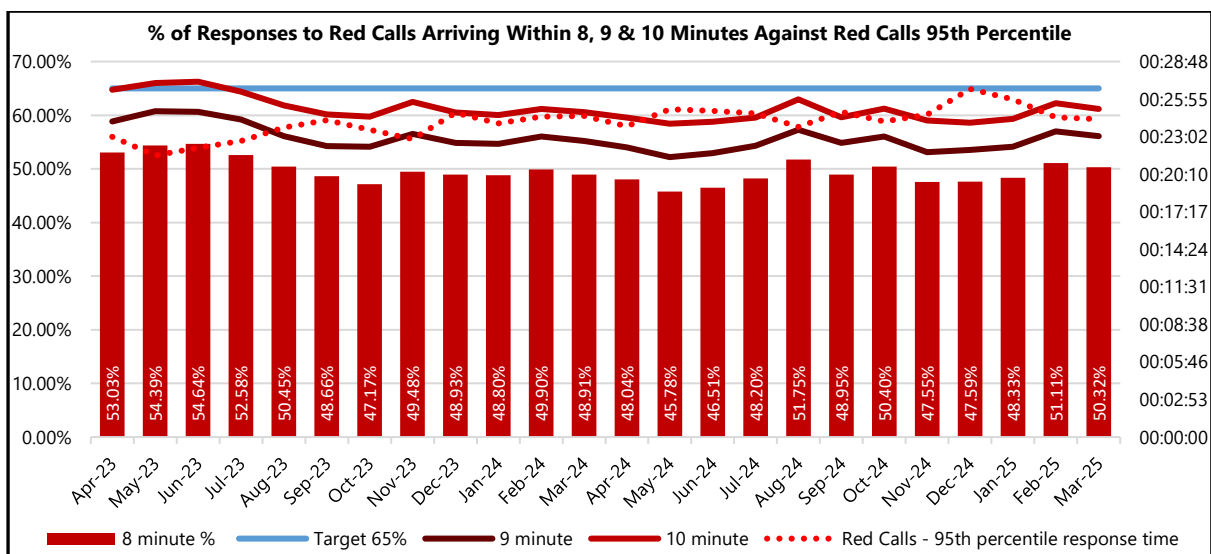
Within the 999 service, the Trust assesses the quality of the service it provides through a range of response time metrics, clinical indicators, and outcome measures. Call answering performance has seen a slight decline during 2024/25 within the 95th percentile of calls averaging 23 seconds, compared to 16 seconds in 2023/24. However, the median call answer time has remained at 2 seconds which is a positive.



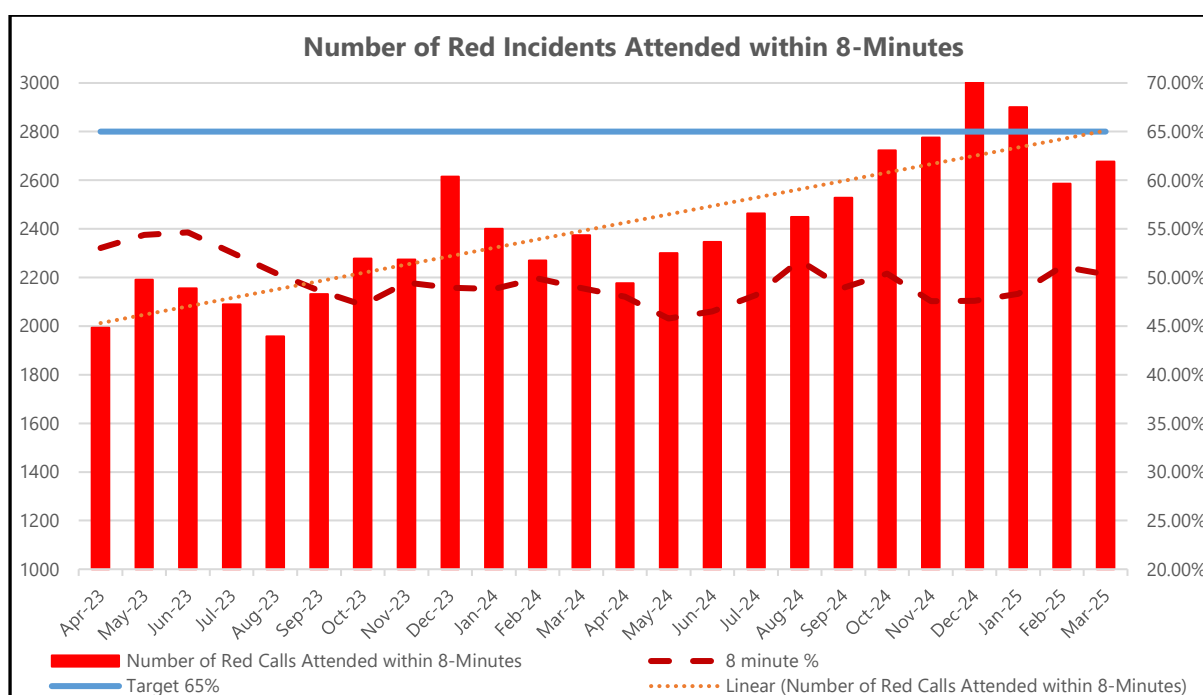
The NEPTS call taking function saw an increase in the average speed of answer during 2024/25, rising to four minutes six seconds, compared to two minutes 17 seconds in 2023/24.

Response Times

The headline patient metric for the Trust is Red eight performance; this is the percentage of Red (immediately life threatening) incidents responded to within eight-minutes. The Trust has unfortunately seen no clear improvement in performance against the Red eight-minute target over the past two years, with the average figure for 2024/25 of 48.7% being a decline from the 50.4% seen during 2023/24 and remaining short of the Welsh Government's 65% target.

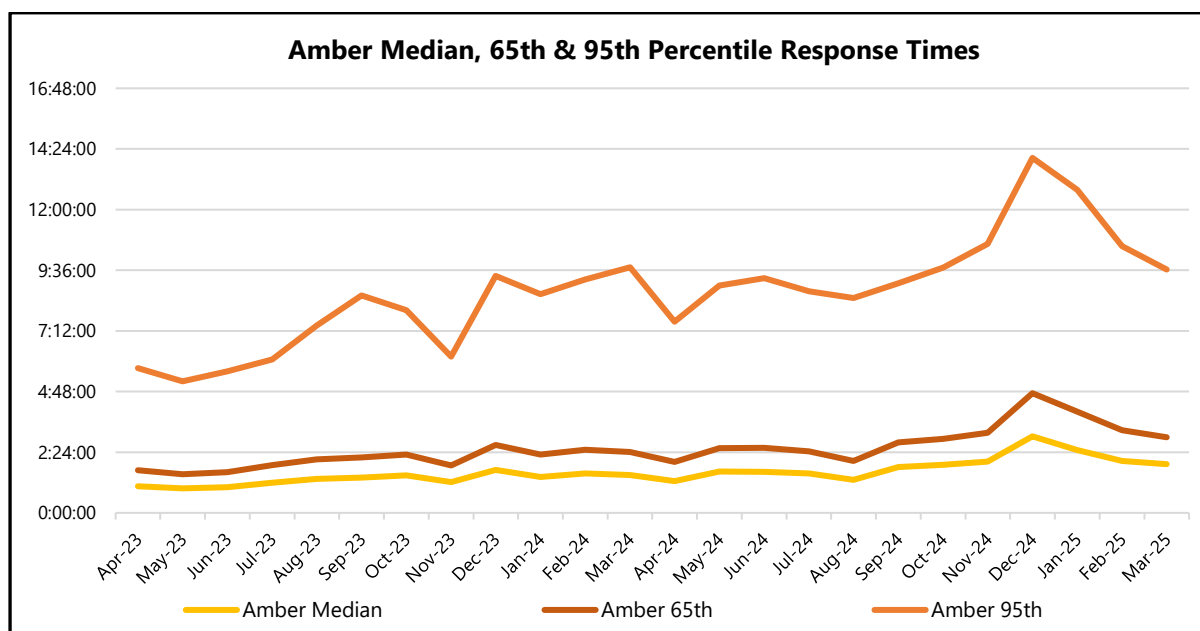


However, there has been a clear increase in the volume of Red incidents attended within eight minutes, as can be seen in the graph below. In 2022/23 the Trust was attending an average of 1,966 Red incidents per month; during 2023/24 this figure rose to 2,227, and during 2024/25 this figure increased again to 2,591. This would indicate an improvement in overall performance, but due to a rise in the number of verified Red incidents over the past year (20.5% increase) this has not been replicated within the Red eight percentage figures.



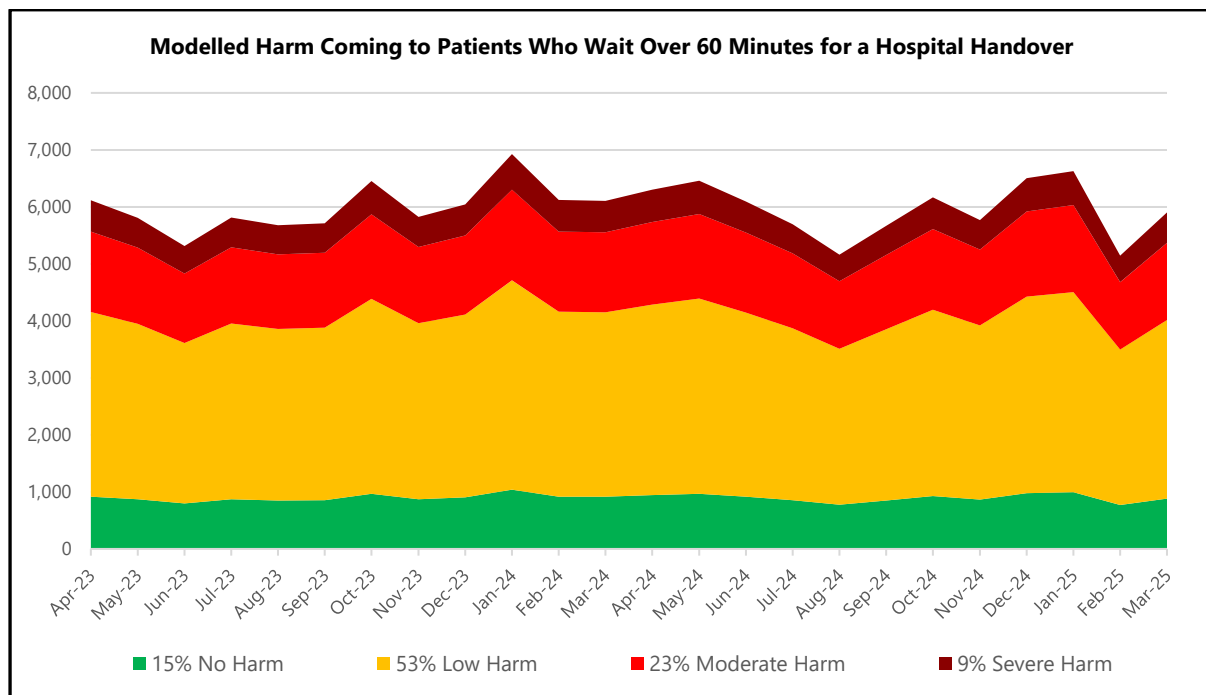
The Trust knows that the bulk of patient safety incidents occur in the Amber category. The Trust's risk register reflects the high concern about long waits in the community and long waits outside hospitals causing unacceptable levels of avoidable patient harm. Although the Trust's resources have been increased alongside continuing initiatives to help mitigate these risks, potential gains continue to be offset by other factors, in particular, the high levels of hours lost to hospital handovers.

During 2024/25, the Trust's Amber median performance was 1 hour 47 minutes; a decline compared to the 1 hour 19 minutes recorded during 2023/24. The year also saw the 65th percentile decline to 2 hours 39 minutes and the 95th percentile to 8 hours 23 minutes.



As previously identified, there are many reasons for longer response times, which include increases in Red demand (rising from an average of 4,489 a month in 2023/24 to 5,406 in 2024/25) and overall acuity; but lost ambulance hours to very long hospital handovers remain the main contributory factor. It has been identified there is a clear correlation between hospital handover lost hours and higher Amber response times.

Notification to handover lost hours averaged 724 hours per day throughout the year and meant that the Trust could have responded to approximately 82,000 more patients if handovers were reduced to target levels, which highlights the impact these numbers are still having upon the system. The modelled harm for patients waiting over 60 minutes for a hospital handover can be seen in the graph below.



Although funding streams remained similar for 2024/25 in comparison to 2023/24, work has been continuing to address some of the rural to urban imbalances within the trust. There were 80 Newly Qualified Paramedics (NQPs) appointed in the Autumn and the majority were recruited into rural areas of Betsi Cadwaladr University Health Board, Hywel Dda University Health Board and Powys Teaching Health Board; improving our staffing levels within these communities whilst also having sufficient levels of staffing in our more urban environments. The Trust has also increased its CHARU establishment to 122.5 FTEs and APP establishment grew from 88.5 to 112.9 (24.4 FTE growth). The majority of these APPs are currently undertaking their MSc course in Advanced Practice, and we are expecting to see the benefit of this recruitment in quarter two of 2025/26.

In relation to the Trust's **Ambulance Care**, demand has been increasing throughout the year; whilst overall Ambulance care demand is still not quite back to pre-Covid levels, patients now requiring an ambulance exceed pre-pandemic levels and average mileage per journey has also increased. Uncertainty around demand remains as Health Boards move through system changes with new days for clinics, and performance in this area remains difficult to forecast. Whilst renal and oncology demand has been stable, outpatient demand is down, and discharge and transfer variable.

The Trust continues to work closely with the Health Boards through the Delivery Assurance Group to deliver the best possible performance for the patient; however, it is likely the service will experience on-going fluctuations in performance until activity begins to normalise once again. A review of capacity against this new demand profile will be required to establish whether service funding remains adequate when compared to the new profile of demand. It is anticipated that there will be challenges in meeting this transitional demand profile.

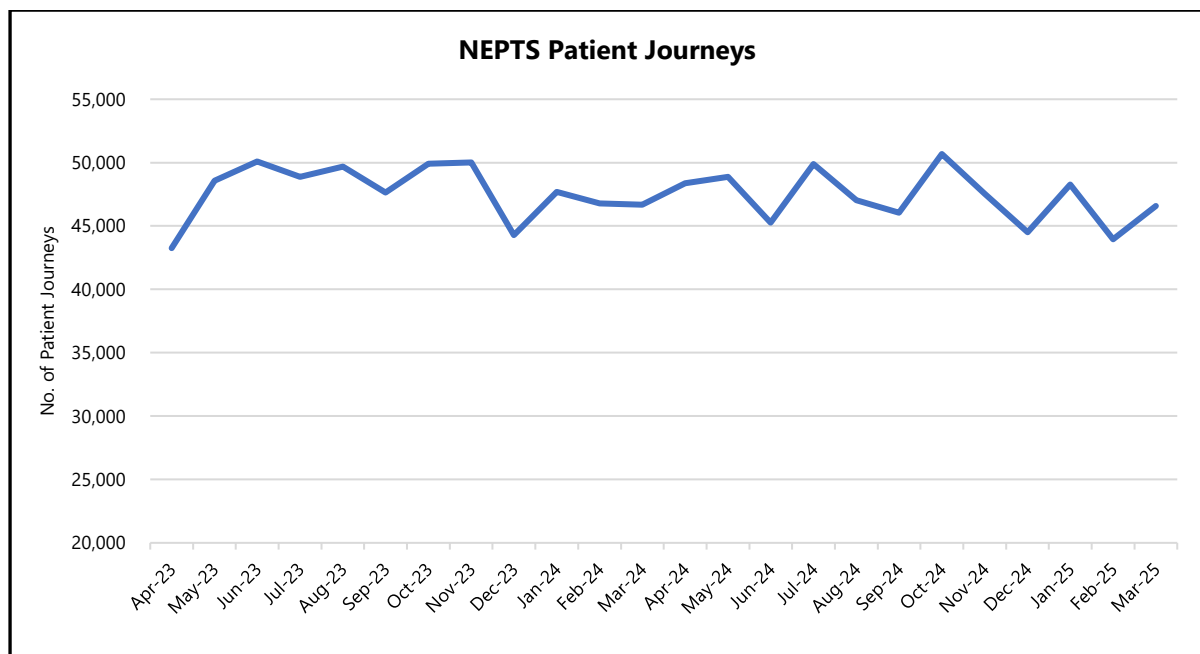
The Trust has recently undertaken a restructure that brought together NEPTS and its Ambulance Care Assistant (ACA) 1 workforce, our Urgent Care Service (UCS) ACA2 workforce, and the Grange Hospital Discharge & Transfer Service, into a new function: Ambulance Care. This is because the obvious synergy of planned transport. Although funding streams are provided separately, there is an opportunity to develop further discharge and transfer services across Wales.

NEPTS transport performance for patients with needs that require the provision of an ambulance has improved and been stable over the last year. However, increases in demand - in particular for Renal patients and higher mobility patients - does impact on the amount of available resource for outpatient activity. Ambulance Care have negotiated these hurdles through utilisation of its Capacity Management Plan and working more efficiently by increasing its resource capacity from renegotiated private contracts. It has been necessary to apply transport eligibility criteria more strictly, which we understand can be disappointing for ineligible users attempting to access transport services.

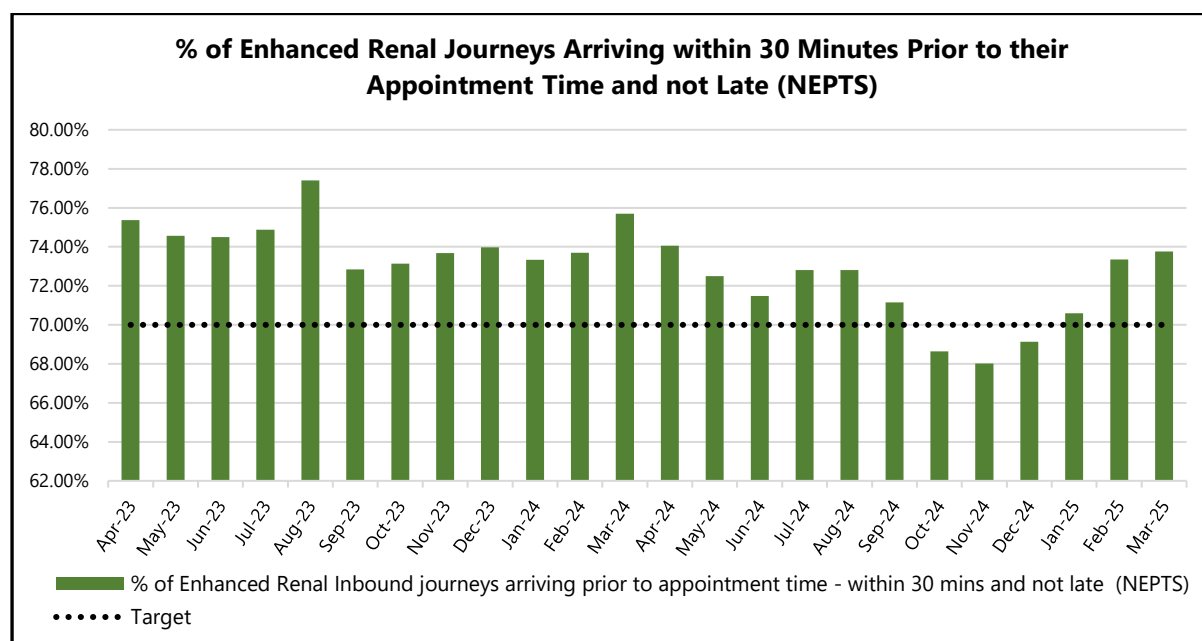
The service is being re-rostered during 2025/26, which will help with the increased demand when implemented. Sufficient workforce and the ability to recruit and retain the NEPTS workforce, particularly within our coordination team will remain an issue during this time. A long term NEPTS strategy workshop was undertaken in quarter one 2024/25 facilitated by commissioners, with the required output to develop a future service vision for NEPTS. It is anticipated that this will be finalised shortly.

Finally, following numerous concerns raised that Unscheduled Care Service (UCS) crews were going to unsuitable incidents, Ambulance Care have been working closely with EMS colleagues to ensure the UCS have a more fit for purpose approach to dispatch that has been modelled, resulting in sufficient ACA2s being funded to deliver this tighter scope.

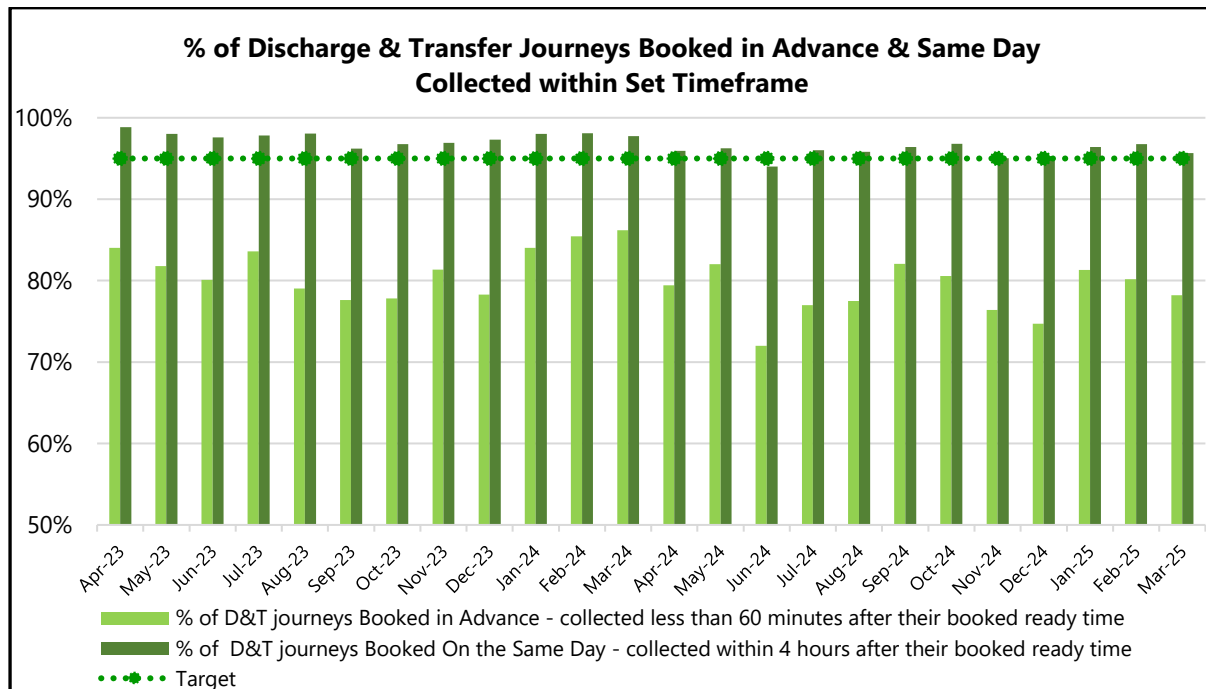
The total number of non-emergency patient journeys undertaken in 2024/25 was 567,008, which while being a further decrease on the 573,463 seen in 2023/24, is still below the 670,353 recorded for 2019/20. However, it should be noted that this new demand profile is now much more complex, with more patients requiring higher levels of support and changes to planned care delivery locations impacting upon journey mileage and planning complexity.



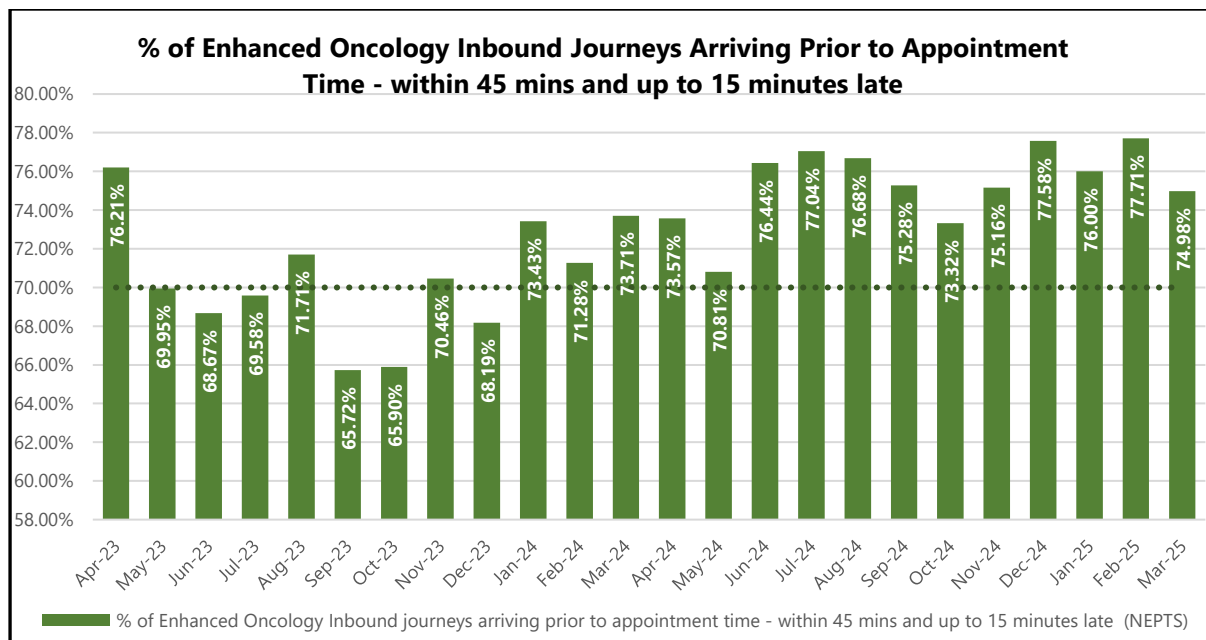
The quality of the service is measured through the various arrival/collection time indicators and new performance standards were introduced in April 2023. Performance has been more stable in some areas, however with enhanced inbound renal patients arriving within 30 minutes prior of their appointment and not late averaged 71.53% for 2024/25, achieving the 70% target in nine of the 12 months.



Discharge and transfer journey performance standards also changed in April 2023 and journeys booked in advance and collected less than 60 minutes after their booked ready time averaged 78% in 2024/25. The standard set for this indicator is 95%, but it is important that this cannot be met without improvements to the efficiency of Health Board advanced planning and subsequent resource reconfiguration. However, journeys booked in on the same day and collected within four hours after their booked ready time is averaging 96% during the same period, achieving the 95% target for 11 months.



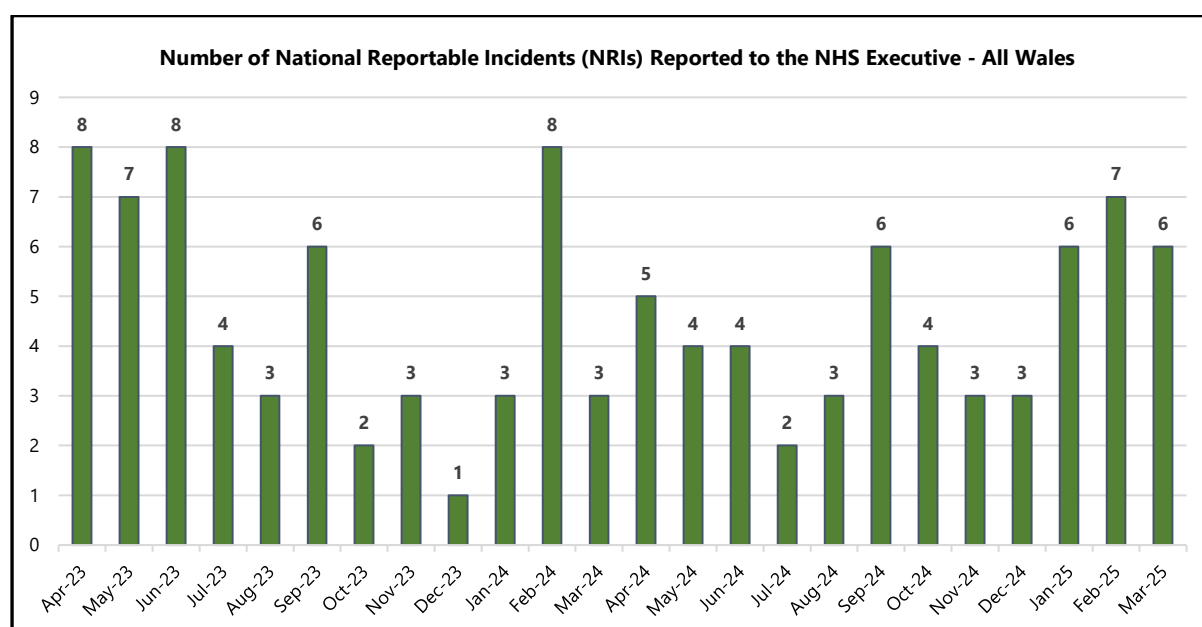
Oncology's new performance standards remain on target with an average 75.38% of inbound oncology journeys arriving within 45 minutes prior to their appointment time, and up to 15 minutes late.



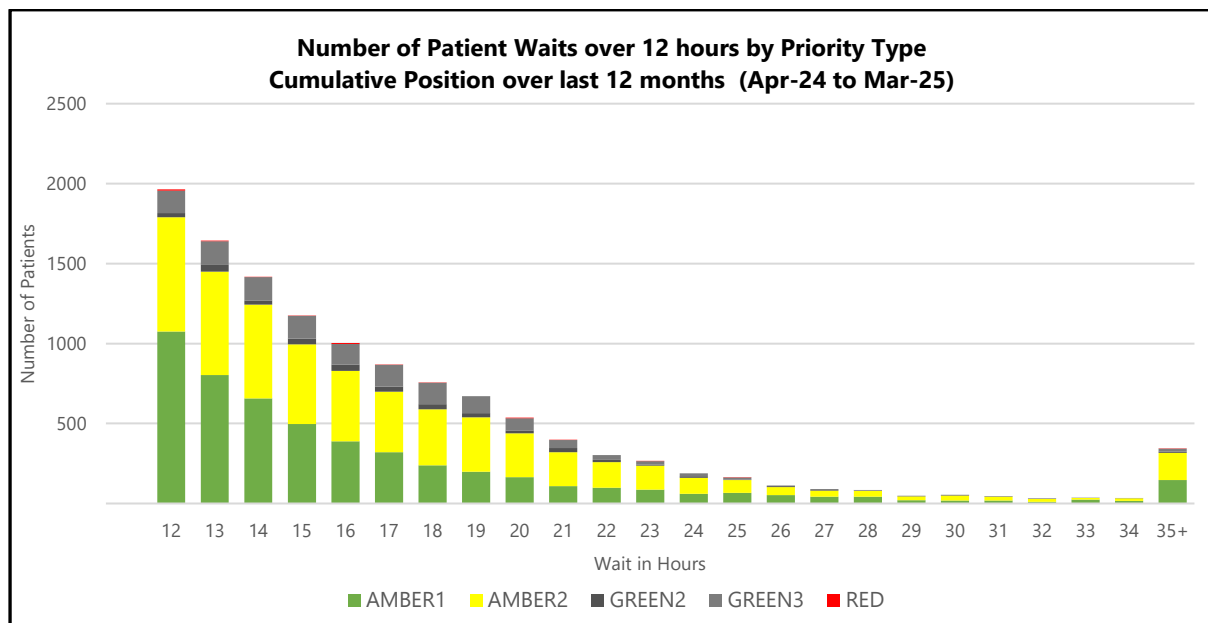
Safety

The Trust actively encourages a positive safety culture and sees all incidents/events as an opportunity for learning and improvement. There were 2,892 patient safety incidents, near misses and hazards reported in 2023/24, compared to 4,400 in 2022/23.

The Trust also saw a reduction in the levels of NRIs and of serious incidents referred to Health Boards for them to investigate. There were 53 patient NRIs in 2024/25 compared with 56 in 2023/24. However, it is recognised that this figure remains too high and reflects the pressures within the health care system. Most, but not all of these NRIs, relate to the Trust's 999 service.

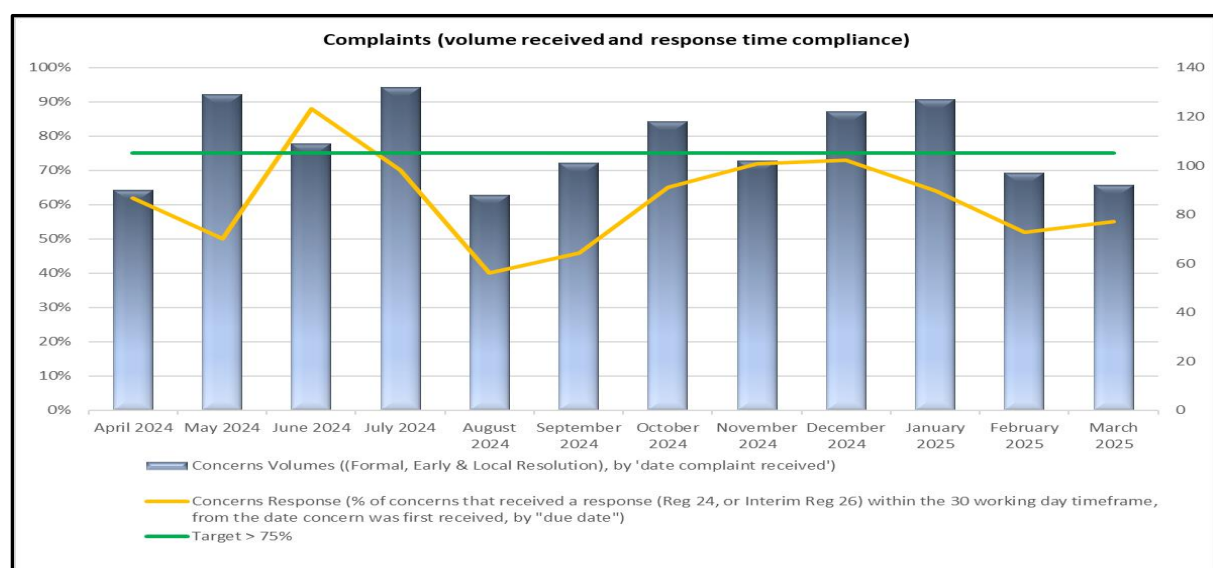


The number of incidents reviewed at the SCIF reported to the Health Boards fell slightly, from 173 in 2023/24 to 166 in 2024/25, although an increase was seen in the last quarter of 2024/25. These are mostly due to long waits in the community caused by handover delays at hospitals, which has seen an increase over the past year. In 2023/24, there were 6,543 patient waits of 12 hours or over, but this number has risen to 10,393 during 2024/25.



The Trust continues to receive large volumes of complaints relating to delayed response times in the community following 999 calls, as well as complaints about short-notice cancellations or delays for non-emergency transport provided by the Ambulance Care service.

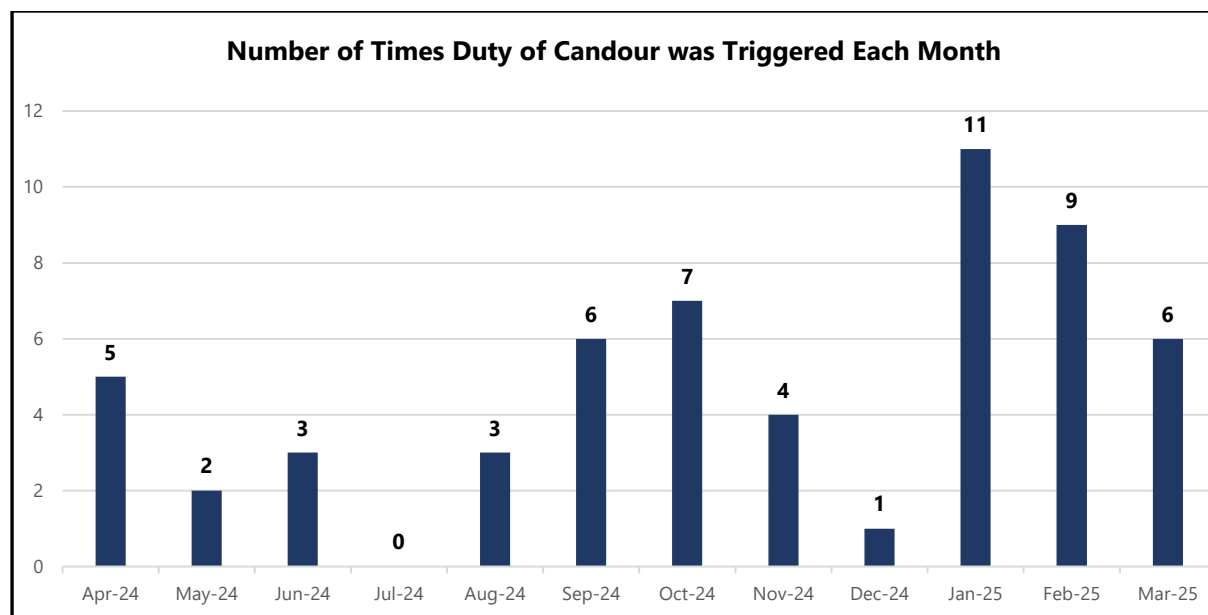
Investment in the Putting Things Right and Legal teams in the Trust has enabled us to provide timelier and more personalised responses to complainants. Full attainment of the 75% target for responses issued within 30 working days has continued to prove challenging when high volumes of complaints are received.





In March 2025, the Trust was named in two Public Interest Reports published by the PSOW for Wales. Throughout the PSOW investigation and publication, our thoughts remained with the families who had lost loved ones, and the additional distress caused that must have been caused by unsatisfactory responses from the Trust. The Trust contributed to the collaborative development of the Ombudsman's recommendations and the action plans resulting from the reports have now largely been completed.

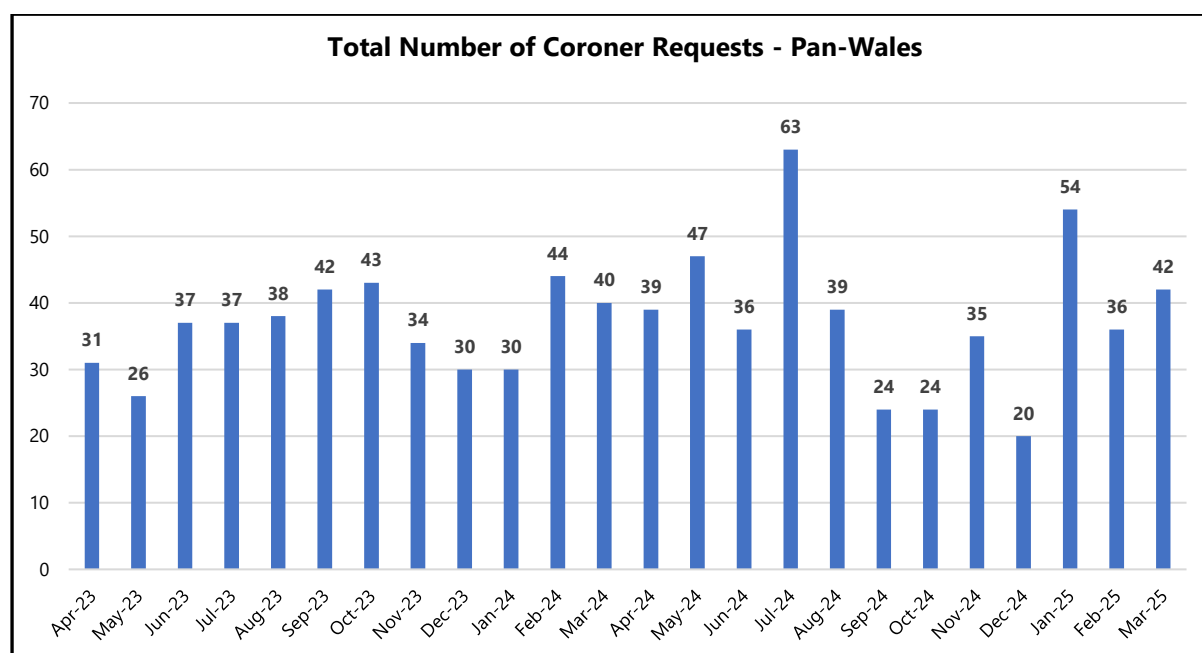
The Trust's Serious Case Incident Forum continues to review all patient safety incidents where the Duty of Candour may be triggered or where the incident might be classed as a Nationally Reportable Incident. The Trust has demonstrated improvements in its identification of cases which fall beneath the NRI threshold but still trigger the Duty of Candour through increased capacity in the Patient Safety team and access to external data sources to review patient outcomes.



The Trust has been working closely with the national Once for Wales Concerns Management Programme team to develop an electronic joint investigation learning repository. This extended use of Datix Cymru is designed to enhance multi-organisation oversight of patient harm and systemic learning. Themes following joint investigations include high levels of system demand, delayed social care discharges resulting in over-crowded Emergency Departments and lengthy pre-hospital waits,

lack of alternative out of hours pathways, opportunities to improve end of life care and Advanced Care Planning.

The Trust's approach to learning from adverse events has been strengthened by transferring the Learning From Events Reports portfolio between teams to place the required improvements closer to the conclusion of investigations. Learning and improving from events are discussed at the Quality Management Group (QMG) and the Clinical Quality Governance Group (CQGG).



The Trust has continued to manage a high number of Coronial cases, with high volumes being received due to regional coroner offices addressing their high number of waiting cases. In addition to large case volumes, further pressure is added by the number of statements being requested, increased numbers of witnesses being called and an increase in the use of jury-based inquests. The Legal Services team provides individualised preparation and support to all Trust staff.

During the year, the *All Wales Learning from Mortality Reviews Model Framework (Second Edition)* was published and the Trust has successfully embedded the nationally proposed approach through contemporaneous triage, multi-professional learning panels and our Learning from Death Forum. This work fits within the Trust's wider commitment to learning from mortality, including from clinical audit, concerns, inquests, patient experience and safeguarding reviews.

The Trust has received four Regulation 28 Prevention of Future Death Reports this year, some of which were issued jointly with other organisations and which largely related to delayed ambulance responses and whether the Trust's model of call-handling and service delivery remains appropriate in the face of such sustained system pressures. The Trust's CMT Programme offers a direct response to these issues and will continue, within the structure of our IMTP, to guide our vision for quality-focused and clinically-driven pre-hospital care.

The Safeguarding Team supports the Trust to discharge its statutory duties and provides assurance that they have been met under various acts, including the Social Services and Well-being (Wales) Act 2014, the Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act 2015, the Children Act 2004, and the Wales Safeguarding Procedures.

The Executive Director of Quality and Nursing is the Executive Lead for safeguarding within the Trust, and the Assistant Director of Safeguarding takes the strategic lead on all safeguarding-related issues. There is extensive partnership working with Regional Safeguarding Boards and other agencies to support the objectives of Welsh Government, Public Health Wales, the Community Safety Partnerships, the Older People's Commissioner, and the Children's Commissioner for Wales. The Safeguarding Team works collaboratively with senior managers and colleagues internally and externally to promote a strong safeguarding culture.

The Trust is committed to fostering an effective organisational culture that encourages professional curiosity, scrutiny, and supports actions required to protect those at risk of abuse or in need of care and support.

Examples of Trust Safeguarding achievements for 2024/2025:

- **Safeguarding Activity:** The Safeguarding Team have responded to a significant increase in safeguarding activity, supporting a Trust response across six Regional Safeguarding Boards for Adult Practice Reviews (APR), Child Practice Reviews (CPR) and Domestic Homicide Reviews. The Senior Safeguarding Team support the Management of Safeguarding Allegations Against Staff and have seen a sharp rise in the number of cases, especially around sexual misconduct.

- **Policies:** The Safeguarding Policy and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Policy, and all associated Standard Operating Procedures (SOPs) have been reviewed and significantly updated to reflect the current safeguarding landscape.
- **Training and Education:** The Safeguarding Team have developed and updated content to support Trust colleagues to have a thorough understanding of safeguarding themes and trends to enable them to identify and escalate concerns in a robust and timely manner.
- **Quality Improvement:** Implementation of Doc-works Scribe update to enable efficient and accurate safeguarding record keeping.
- **Support, Advice and Guidance:** Over 1,300 colleague enquiries recorded, with the most common reasons being Doc-works Scribe and Reflective/Retrospective Safeguarding Advice.
- **Procedural Response to Unexpected Death in Childhood:** Involved in 58 child death cases, contributing to Public Health Wales in recognising themes and trends.

Patient Experience and Engagement (PECI Team)

The PEGI Team have been focused on capturing the experiences and views of people who have used our services during the year. Peoples experience is defined by what it feels like to access and receive care from the Trust, it is based on peoples' own perceptions of the care and treatment they received.

Key themes reported have consistently focused on response times for an emergency 999 call and the repetitive questioning when someone is calling back. Linked to response times are estimated time of arrivals given to patients not being accurate; even though explanations are provided on why this happens. Although feedback has been generally negative regarding access it has been very positive in relation to the care and compassion that staff have provided to patients once on scene.

Regarding Ambulance Care (NEPTS) it is the wait time for transport home following a patient's appointment that is a regular negative theme; for all other aspects of the service people have reported excellent experience and service.

Through the Trust's continuous engagement, it is aware that parts of our communities (e.g. Deaf and learning disability) are reporting poorer experiences, and work continues to ensure they receive better quality experiences, feedback with areas for improvement being coordinated through the QMG and the National Service User Experience Meetings.

The Trust captured peoples' experiences using a variety of methods including face-to-face engagement, service experience surveys, patient stories, and our 'Have your say' online facility. We recognise that we need to increase our experience data and have been working with Information Governance team on a Data Protection Impact Assessment for submission to the Information Commissioner's Office (ICO) so that we can look to incorporate SMS text messaging to improve our experience returns and widen our reach for feedback.

The 'People & Community Network' has grown over the year with network members participating in a number of activities to improve public facing resources designed to provide health information and support.

On 01 October 2024, the Learning Disability dashboard went live enabling the Trust to view reports on data of a patients' additional need. The dashboard sorts data according to demographics (age range, gender) and other categories i.e. incident closure type and call prioritisation. Within the first six months there were over 1500 ePCR records where an additional need had been recorded.

Convulsions/fitting and breathing problems have been in the top two nature of incidents recorded. This data is valuable in helping to understand the wider national picture of health amongst the learning disability population and their impact on patient experience. The PECCI Team continue to engage with local communities to capture experience data around people's lived experiences to support the ongoing improvements in care and patient experience and outcomes.

The PEGI Team received some external recognition for their work around learning disability. A poster abstract entitled 'Improving the experiences and outcomes of learning disability patients when accessing emergency care' was successful for submission under the category of 'Populations' at the Internal Forum on Quality and Safety in Healthcare being held in Utrecht in May 2025. This work has also drawn attention from the emerging network for Ambulance sector learning disability leads.

At the October 2024 National Patient Experience Network Awards (PENNA) in Birmingham, the team had three entries all making the final. The awards recognised best practice in patient experience across all facets of health and social care in the UK. The categories were:

- 'Engaging/Championing the public': promoting our work on improving experiences of people with learning disabilities.
- 'Innovative use of technology/social and digital media': for our work with children and young people in developing the blue light app based on evidence-based research, using technology and digital solutions to engage (Runner-Up in this category).
- 'Partnership Working to improve the Experience': promoting our work across all health, social care, business and voluntary sectors to reach, engage and improve experiences of communities across Wales.

After being named runner up at the PENNA awards in the 'Innovative Use of Technology, Digital & Social Media' category for the blue light gaming app, an evaluation, created in collaboration with Cardiff University, was also published in the EMJ, following its original publication in the BMJ. The latest update to the app included a Cardiopulmonary Resuscitation (CardioPR) awareness game that has attention to medical accuracy and tonality. It is anticipated that this will increase awareness across a critical topic to help improve skills and confidence in using CardioPR.

A member of the team was invited to provide a rapid elevator presentation at the '999 EMS Research Conference: recognising progress, developing the future'. The conference, held in person on Tuesday 17 and Wednesday 18 September 2024 in Cambridge was hosted and supported by East of England Ambulance Services NHS Trust. Our presentation was entitled "When you're hurt, and you need serious help you call 999". Educating children about emergency services and appropriate use of 999: An evaluation study of the Blue Light Hub app".

The app is free to download at Google Play and Apple: -

Google:

<https://play.google.com/store/apps/details?id=com.WelshAmbulance.BlueLightHub>

Apple:

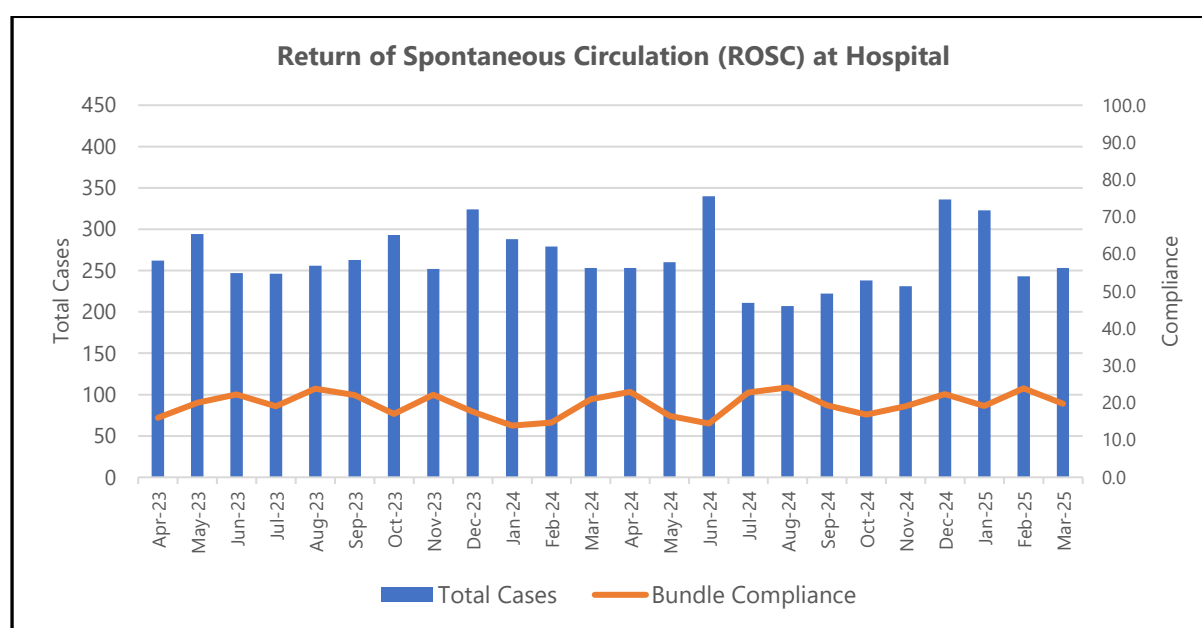
<https://apps.apple.com/us/app/blue-light-hub/id1575745545>

Clinical Indicators

Introduced through 2022, the ePCR is now fully embedded within the Trust and has significantly enhanced the collection and sharing of clinical information. As anticipated, this has led to improvements in the completeness and accuracy of clinical data capture, supporting more robust reporting on the five key clinical indicators: Fractured Neck of Femur (fractured hip), Stroke, ST Elevation Myocardial Infarction (STEMI, (heart attack)) Hypoglycaemia (low blood sugar) and Return of Spontaneous Circulation (ROSC) (from cardiac arrest). Each indicator is made up of individual agreed elements that are all evidenced based and indicative of delivering a better patient outcome. In the Trust all incidents matching the agreed criteria of the five conditions are included in the reporting. Following the embedding of ePCR, further deep dive quality assurance audits and subsequent improvement initiatives, such as the rollout of 'Top Tips' guidance, enhancements to the ePCR user interface, and the development of clinical dashboards have all contributed to improved compliance with documentation standards.

From the start of April 2024, the Trust embarked on a six-month improvement exercise to improve the clinical indicator performance. To support this initiative, a programme of engagement and education was commenced to ensure a robust and consistent message was relayed to all clinicians delivering care and using the ePCR to record their consultations. This included poster campaigns, digital messaging in the form of lock-screen infographics displayed on ePCR devices, and engagement stalls at each of the CEO roadshows across Wales. The six-month improvement plan which was carried out between April and September 2024 delivered an improvement in all clinical indicator compliance.

One of the clinical indicators the Trust currently measures is the percentage of patients who have ROSC at hospital. Although for the year 2024/25 this remains lower than the Trust would want it has shown an improvement on 2023/24.



Of the other key clinical indicators the Trust measures, none of them achieved the 95% target during 2024/25, although there were some improvements in performance seen in many areas.

There were also improvements seen in the percentage of older people with suspected hip fracture who are documented as receiving the appropriate care bundle; the percentage of STEMI patients who are documented as receiving the appropriate care bundle; the percentage of hypoglycaemic patients who are

documented as receiving the appropriate care bundle, and the percentage of suspected stroke patients who are documented as receiving the appropriate care bundle, with the figure for March 2025 of 91.6% being an improvement on the 72.8% reported for March 2024.

The Trust has continued to grow its CHARU service across Wales to a position where it is now just 18 FTE short of its 140.5 FTE target pan-Wales. The Trust is recruiting into this role in quarter one 2025/26 and expect to see the remainder of the vacancies filled in quarter two. This service is aimed at providing a response to a dedicated code set of high acuity incidents by an experienced paramedic with additional medicines and training. They will support clinical decision making, co-ordinate patient care and ensure clinical practice is in line with current best practice guidelines to improve overall outcomes in several of the areas highlighted above, such as successfully increasing ROSC rates.

1.9 Our People

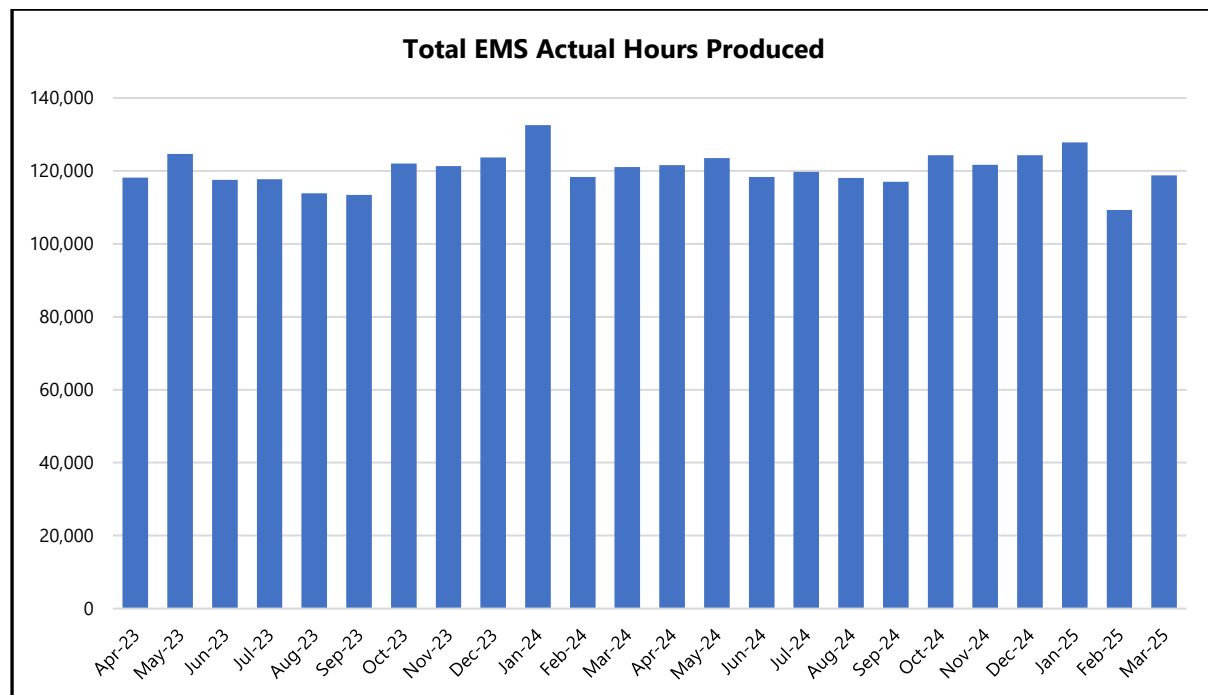
In relation to the Trust's workforce, the indicators reviewed at Board relate to whether the Trust has the right workforce capacity in place to meet demand, how the Trust is keeping staff safe and well, and how they are being developed. More detailed and numerous indicators are also considered at the PCC.

The Trust had a budgeted establishment of 1,823 FTEs for EMS in 2023/24. This establishment increased to 1,904 FTEs in 2024/25. This reflects the Trust's commitment to growing roles such as CHARU and APP in EMS which have seen a considerable rise in the planned establishment. CHARU numbers increased to 122.5 FTEs during 2024/25, while APP establishment grew from 88.5 to 112.9 (24.4 FTE growth). The majority of these APPs are currently undertaking their MSc course in Advanced Practice, and we are expecting to see the benefit of this recruitment in quarter two 2025-26.

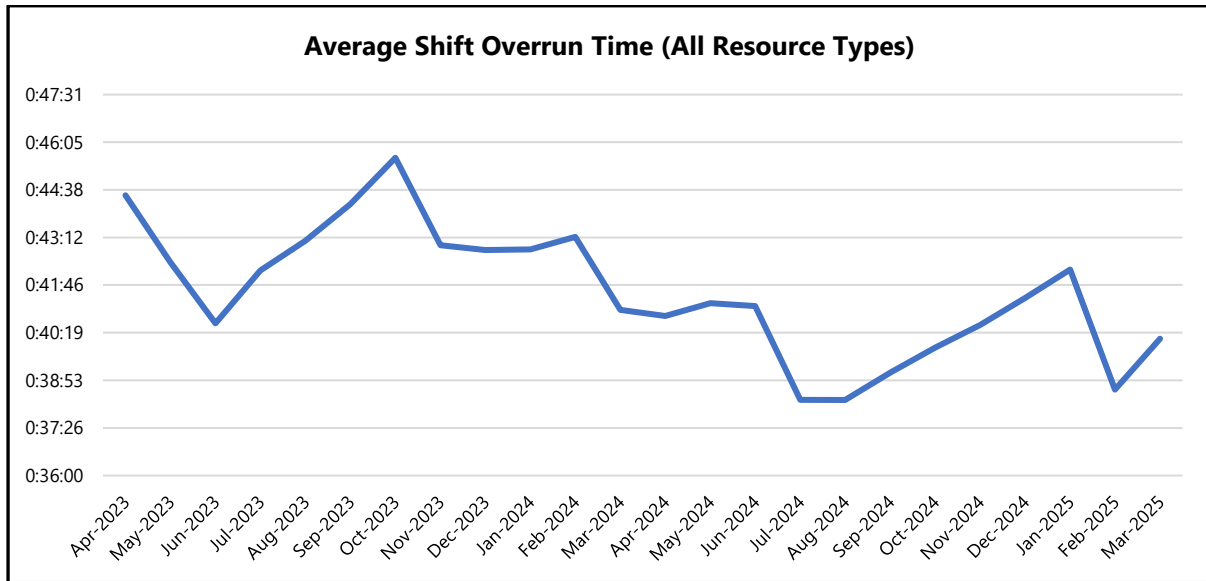
Discussions around the future skill mix of our EMS workforce are ongoing, which could have considerable impacts going forward. However, sufficient training capacity has been planned during 2025/26 to enable the Trust to recruit any staff into the organisation, regardless of what grade that may be.



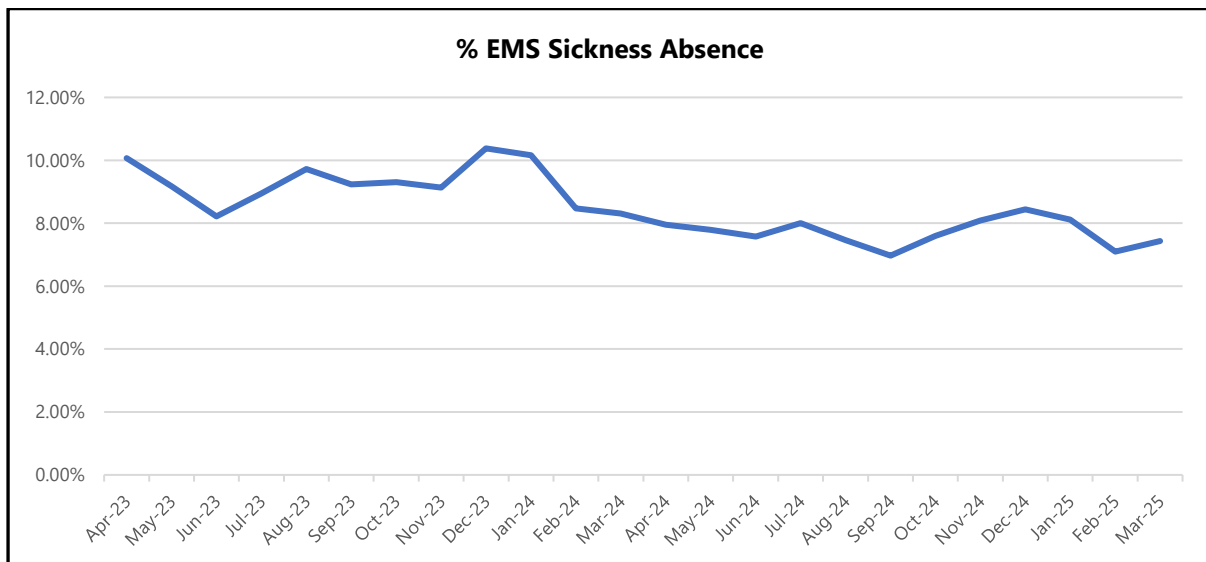
The graph below demonstrates the number of EMS ambulance unit hours it is able to produce in 2024/25 compared to the previous year and highlights it has remained relatively stable. In 2024/25, 1,444,419 actual hours were produced compared to 1,444,431 hours in 2023/24. These hours are an uplift in the number of EMS hours produced compared with previous years, prior to 2023; but this gain has been offset by the continued high number of hours lost to handovers at hospital.



The Trust has also seen a reduction in the average number of shift overruns during the last year, as can be seen in the graph below. This highlights that the average shift overrun per month has reduced from 42 minutes 58 seconds during 2023/24 to 40 minutes 8 seconds in 2024/25.

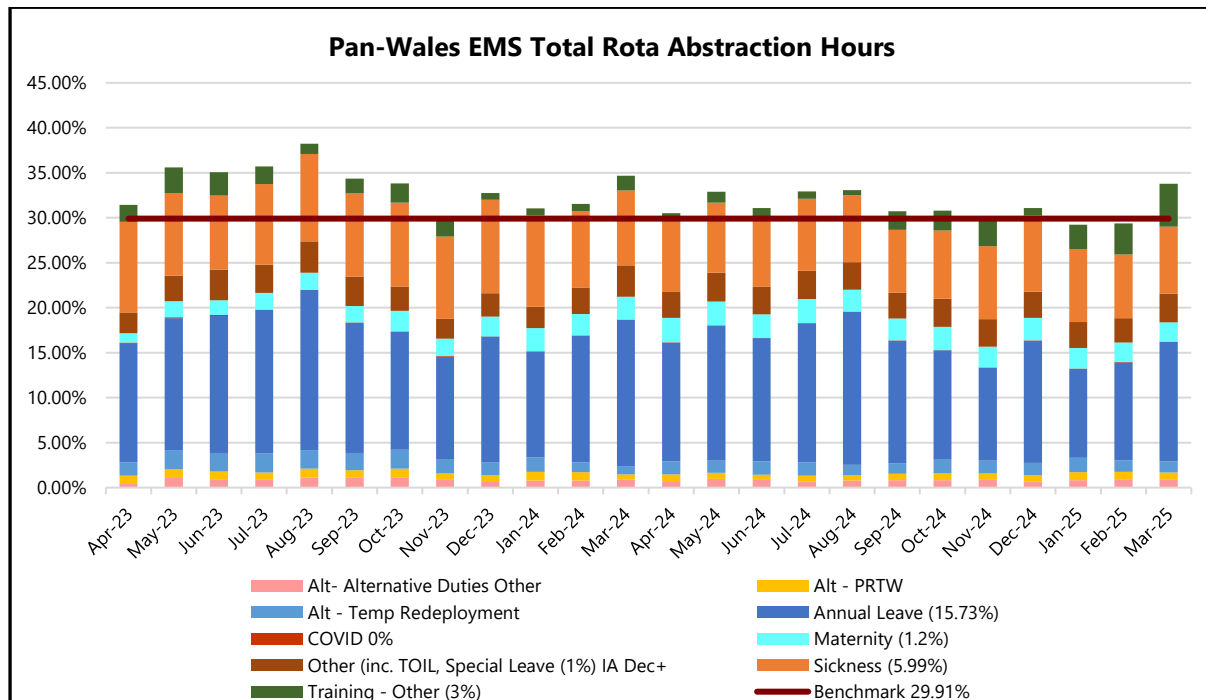


Another key factor in the Trust's ability to ensure capacity to meet the demand is the impact of roster abstractions, and this also provides an indicator of our people's well-being. To support the workforce there has been an ongoing focus on well-being activities across all areas of the Trust, including those in both frontline and support roles.



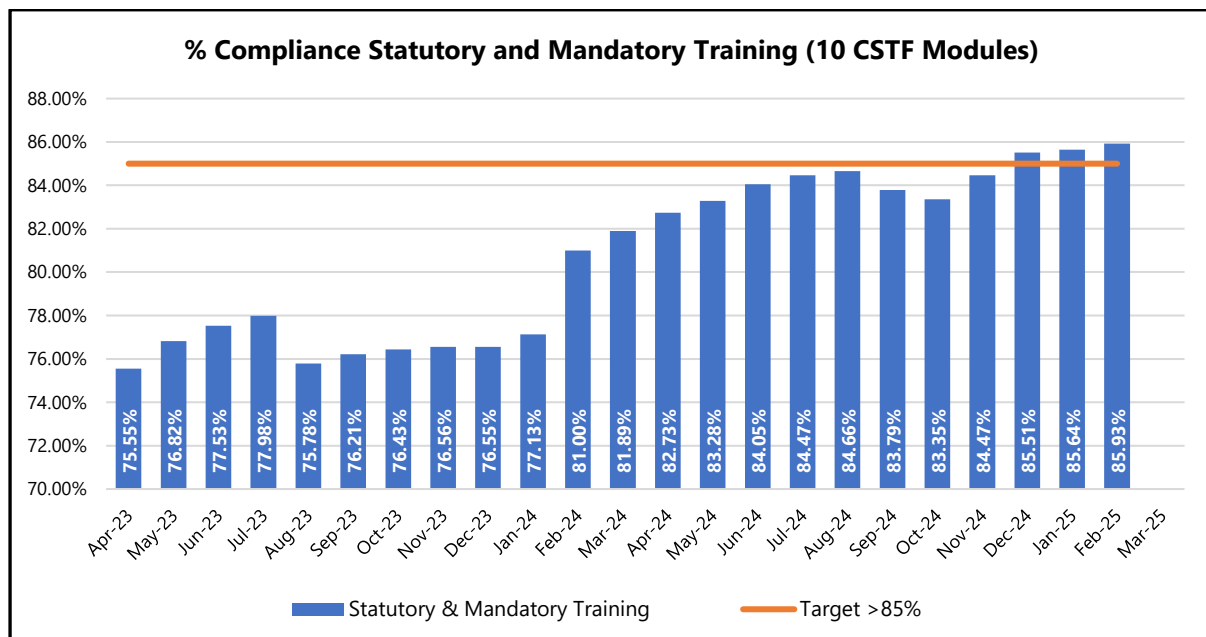
The graph above shows the level of abstractions due to sickness over the past two years for EMS staff. In 2023/24, the average sickness rate per month was 9.26%, but this rate reduced to 7.71% during 2024/25. However, this figure still remains above the Trust's year-end sickness target of 6%.

The graph below shows there has been an improvement in overall EMS abstractions over the past two years, with a monthly average rate of 31.3% in 2024/25 compared to 33.7% in 2023/24. The 30% target has also been achieved in three of the past six months having only been achieved once prior to this over the past three years.

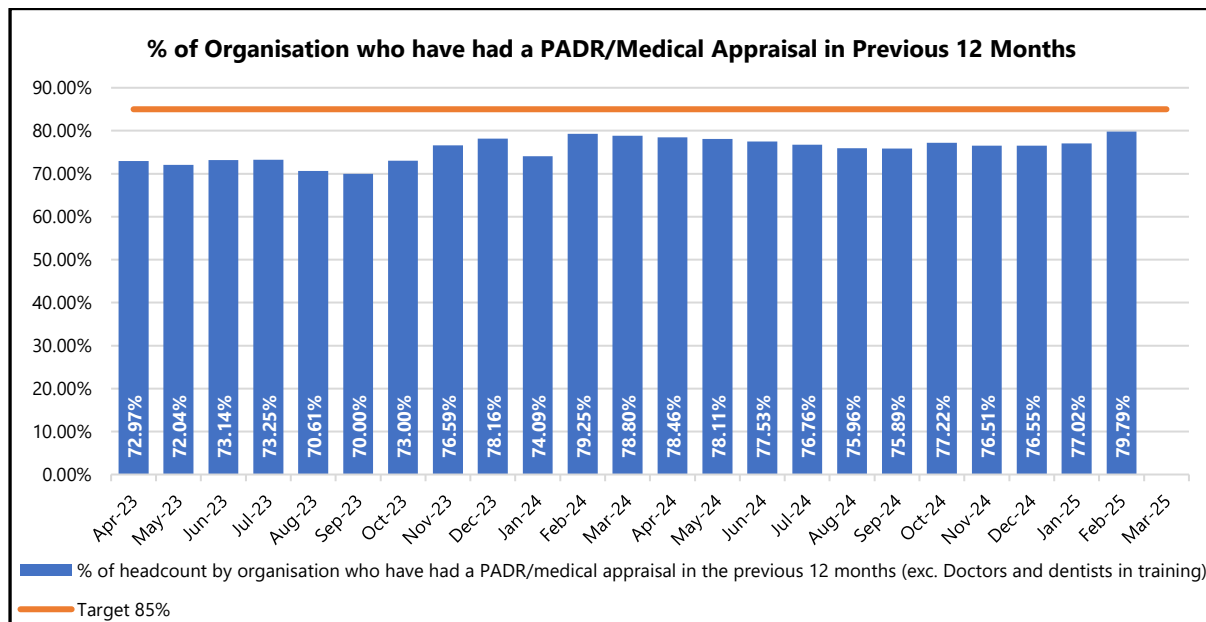


Conflicting pictures were seen within 111 and Ambulance Care. 111 saw an average abstraction rate, due to sickness, of 9.3% in 2024/25, up from 8% the previous year, while Ambulance Care saw sickness rates drop from 10.3% in 2023/24 to 9.5% in 2024/25. The Trust is fully aware that sickness absence needs to remain a major area of focus over the coming year in order to ensure that sickness reduction targets are met and is fully committed to a number of initiatives including training for managers and wellbeing sessions for staff. The full sickness rates can be found within the Staff Report, within the Accountability Report.

Statutory and Mandatory Training rates achieved the 85% target overall at year end, recording over this rate for the last four months of the year. This follows a gradual improvement seen since January 2024.

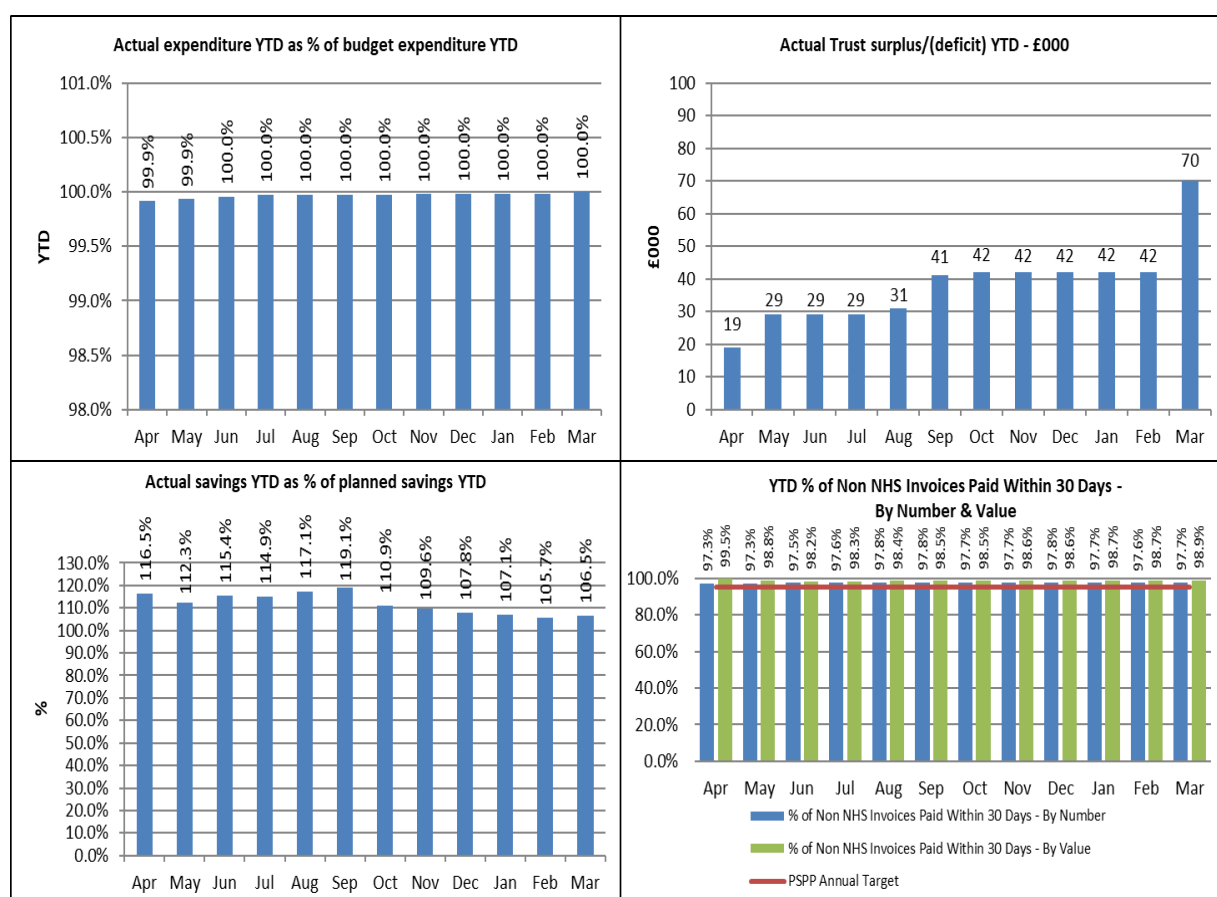


In terms of staff development, the Trust views levels of PADRS as the best way of representing development at a high level. Although the year end figure for 2024/25 of 79.8% failed to achieve the 85% target, it has shown a sustained gradual improvement over the past two years.



1.10 Finance and Value

The Trust reviews a number of indicators which aim to demonstrate how it provides a service in line with statutory financial duties, and of high value and efficiency. This area of the Performance Report will be strengthened over time as the value-based health care programme continues. The Trust achieved financial balance in 2024/25, with a small revenue surplus of £70,000 alongside delivering capital expenditure within its Welsh Government set Capital Expenditure Limit, thereby meeting its statutory duty to breakeven during this financial year.



Gross savings of £6.838m were achieved against a target of £6.421m, thus an over achievement of c.6.5%. Public Sector Payment Policy was on track with performance of 97.7% for the number, and 98.9% of the value of non-NHS invoices paid within 30 days (target 95%). Further information can be found in the Trust's annual accounts and financial statements, which have been prepared on a going concern basis.

The Trust's financial plan for 2025/26 is one of balance but predicated around delivering a savings target of c£8.5m which is c£2m more than the 2024/25 planned target.

1.11 Non-Financial Performance Information

Human Rights, Diversity and Equality

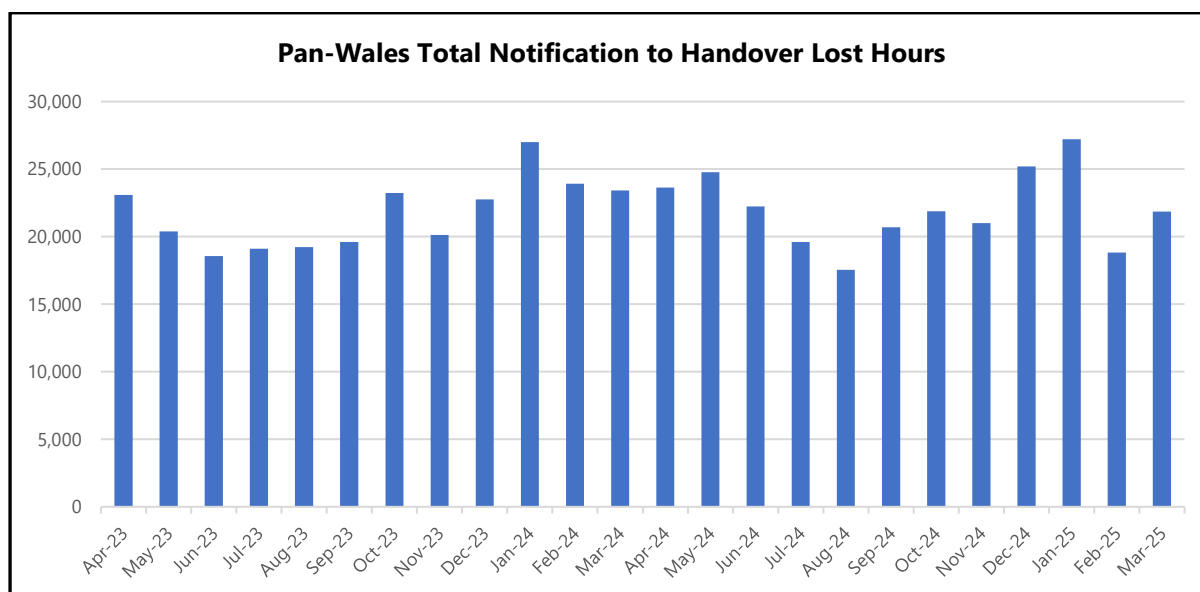
The Annual Governance Statement in the Accountability Report discloses how the Trust meets its obligations under equality, diversity, and human rights legislation. Refer to the Disclosure Statements and the Modern Slavery Act 2015 statement for further information. There is also additional commentary regarding 'Other Employee Matters' in the Remuneration and Staff Report, within the Accountability Report.

Anti-corruption and Anti-bribery

The Annual Governance Statement also includes narrative regarding the Trust's counter fraud arrangements, and the Local Counter Fraud Specialist's relationship with the Audit, Risk and Assurance Committee (ARAC). This narrative can be found in the 'The Control Framework' section of the Accountability Report.

1.12 Partnerships and System Contribution

The Trust aims to consider both its impact on the wider system, but also the wider system's impact on its service. Although handover lost hours reduced in 2023/24 compared to 2022/23, they have risen slightly again this year, averaging 22,003 hours per month during 2024/25 compared to 21,700 a month in 2023/24. This figure remains extreme and equates to 1,834 twelve-hour shifts and meant the Trust could have responded to over 3,454 more patients each month if handovers were reduced. The total ambulance hours lost during 2024/25 was 264,393, meaning the Trust is losing between a quarter and a third of its conveying ambulance production.



The Trust is aware that Health Boards introduced urgent and emergency care escalation frameworks during 2024 to try and reduce lost hours to handover, following strong messaging from Welsh Government and the Cabinet Secretary for Health and Social Care that this issue must be tackled as a matter of priority. A series of Integrated Commissioning Action Plan (ICAP) meetings were also established by the National Collaborative Commissioning Unit, designed for individual Health Boards and the Trust to work collaboratively in order to reduce handover hours.

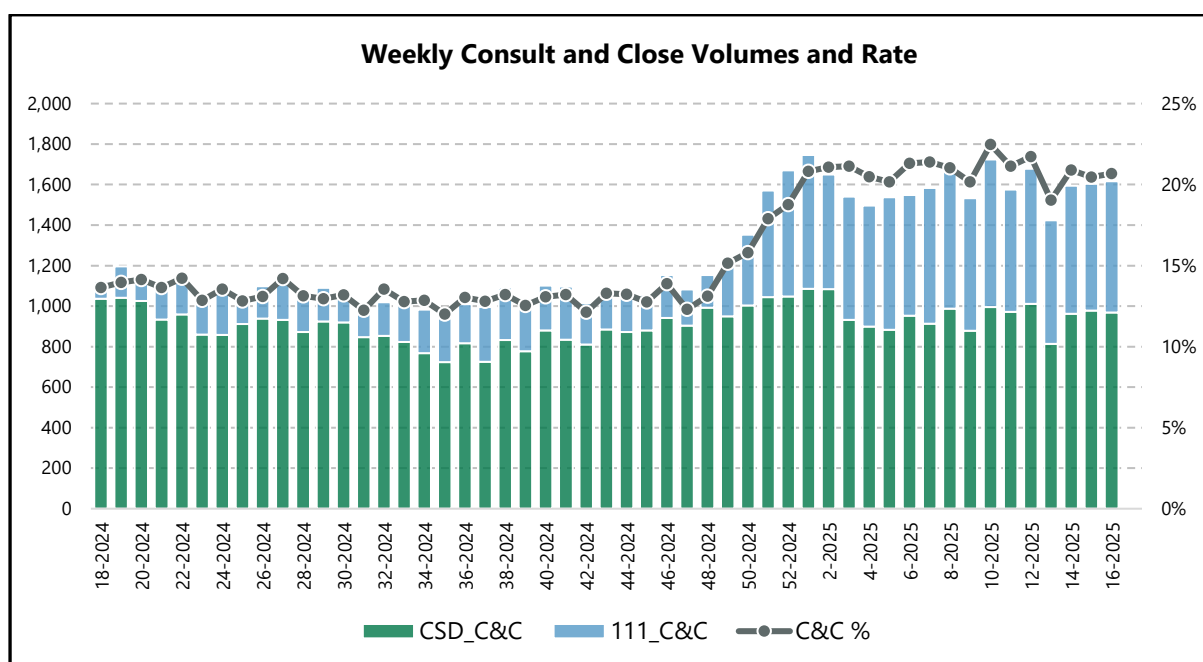
Although overall levels over the year did increase, there were some positive signs in February and March 2025, with both months showing reductions on the same period last year. Although early days, this may be due to the reduction in the number of conveyances seen into EDs since the introduction of the Remote Clinical Screening process, as part of the CMT programme.

When considering individual Health Boards, only Cardiff and Vale University Health Board (CVUHB) have been able to sustain a reduction in lost hours throughout 2024/25, with the average number of lost hours each month within CVUHB being just 840. In contrast average lost hours per month in Betsi Cadwaladr rose to 8,256. Both Hywel Dda and Swansea Bay did see reductions in lost hours in 2024/25 compared to 2023/24, with Hywel Dda reducing to 3,224 (compared to 3,313 in 2023/24) and Swansea Bay reducing to 2,944 (compared to 3,548 in 2023/24). All other Health Boards recorded an increase.

Given the scale of the challenge and its links to wider system pressures, the Trust is having to plan on the basis that lost hours will remain high for the foreseeable future and acknowledge they will continue to cause patient harm. The Six Goals Policy Handbook set out an expectation of no handover being longer than an hour by 2025, which would equate to 7,000 lost hours per calendar month, much lower than the +20,000 hours the Trust is currently having to operate in. It should also be noted that the Trust's current EMS roster keys are predicated on 6,000 hours per calendar month.

The Trust is committed to transforming its services to become more sustainable, to get patients to the right service, in the right place, every time, and to reduce the reliance on emergency departments as the default location for definitive urgent and emergency care, something which is at the forefront of the new CMT programme.

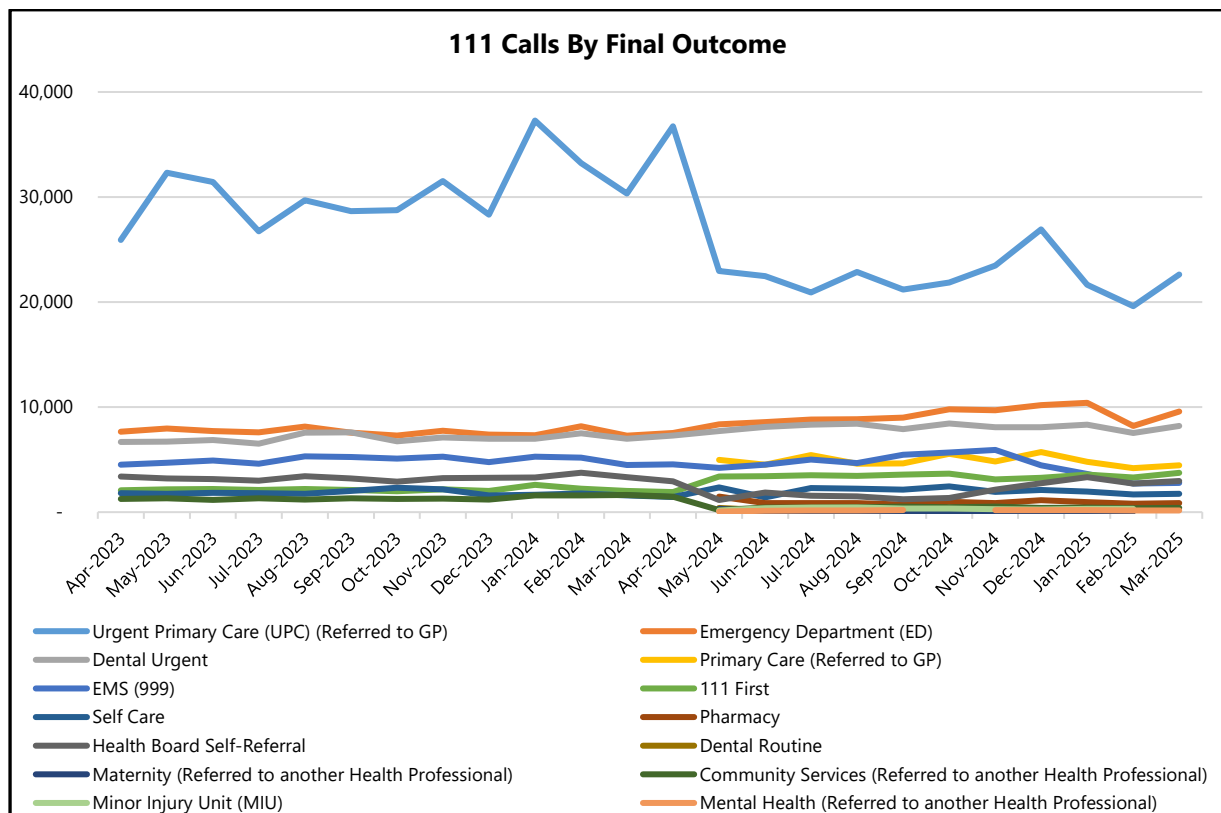
One of the key areas where the Trust already supported the system in reducing demand is 'Consult and Close' through the work of the CSD and 111. The 2024/25 'Consult and Close' Welsh Government target was set at 17%. There have been some issues with collecting data on this metric from October 2024, due to the decision to turn off the old reporting system. However, following more robust reporting, recent data suggests that the figure over the past 4 months has averaged around 20%, as indicated in the graph below.



The CSD establishment remained stable over the past year, which has impacted on the Trust's ability to impact its 'Consult and Close' rate and volumes. However, clinician numbers will be reviewed as part of the 111 roster practice review in early 2025/26.

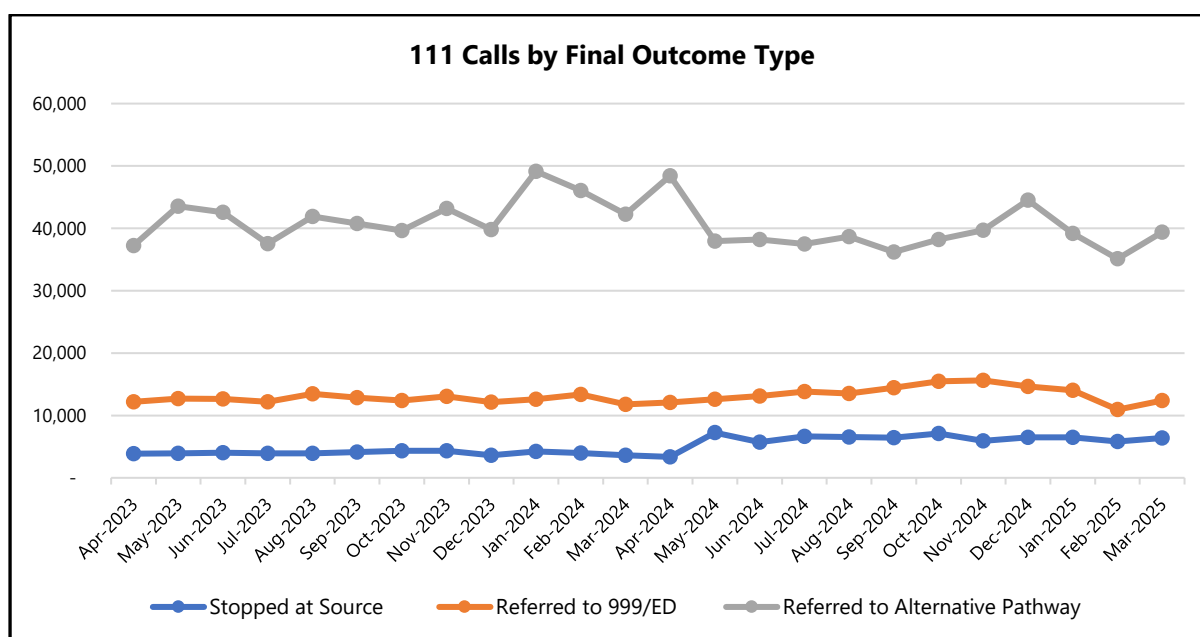
The Trust also monitors its 'See and Treat' rates and those treated at scene, which have increased slightly against responded incidents year on year, rising from a monthly average of 17.1% in 2023/24 to 17.8% in 2024/25. This equates to an average of 3,716 patients being treated at the scene each month throughout the year. The Trust's strategic ambition remains to increase this 'shift left' activity and reduce the number of patients that need to be conveyed to emergency departments.

In relation to the Trust's 111 service, one of the success factors is getting the patient to the right service, first time. The categorisation of some of these outcome measures has changed during 2024/25, as work has been undertaken to improve 111 data metrics, allowing more meaningful data to be reported and identifying whether these outcomes are the best and most appropriate.



The graph above highlights where callers to the 111 service are currently directed, with those being referred to a General Practitioner comprising the biggest percentage for the year (33%). Currently about 19% of 111 calls are referred to 999 or advised to attend an ED.

The graph below simplifies the response patients received, with the blue line highlighting those who were effectively 'stopped at source'. It indicates that this figure has remained relatively stable during 2024/25 at around 10.5% of all known outcomes.



1.13 Infection Prevention and Control

Infection Prevention and Control (IPC) continued to be a critical component of healthcare in 2024/2025. The IPC team has had to navigate several challenges throughout the year, influenced by factors such as workforce changes, leadership transitions, staffing shortages and a reduction in training opportunities. These factors have impacted the team's capacity and operational effectiveness, highlighting the need for thoughtful reflection and targeted improvement. As a result, the majority of activity was conducted in quarters three and four. Key performance indicators for the IPC team during 2024/25 include: -

1. Rollout of Respiratory Protective Equipment (RPE)

- Developing and managing a development of the rollout in the North Wales Region.
- Managing the rollout to the rest of the Trust from Hensol.
- Development of the Powered Air Purifying Respirators (PAPR) standard operating procedure.
- Processing and distributing 930 PAPR kits to frontline EMS vehicles, ambulance care localities, volunteers' sectors, response capable officers and HART.

2. Managing IPC Incidents and Outbreaks

One of the key functions of the team is to provide leadership in managing IPC related incidents within the Trust. During 2024/25 5 cases of Meningococcal disease, 4 cases of Invasive Group A Streptococcus and 1 case of Lassa Fever were all managed by the IPC team.

3. Quality Assurance Audits

The WAST IPC audit programme aims to reduce the risk of infections acquired by patients during pre-hospital care. This is achieved by ensuring compliance with the organisations established standards and guidelines. Audits conducted in the last quarter included: -

- Hand Hygiene Audit – 60 completed across 8 sites, with an average score of 60%.
- Vehicle Cleanliness Audit – 24 completed with an average score of 84%.

4. Policies and Guidelines

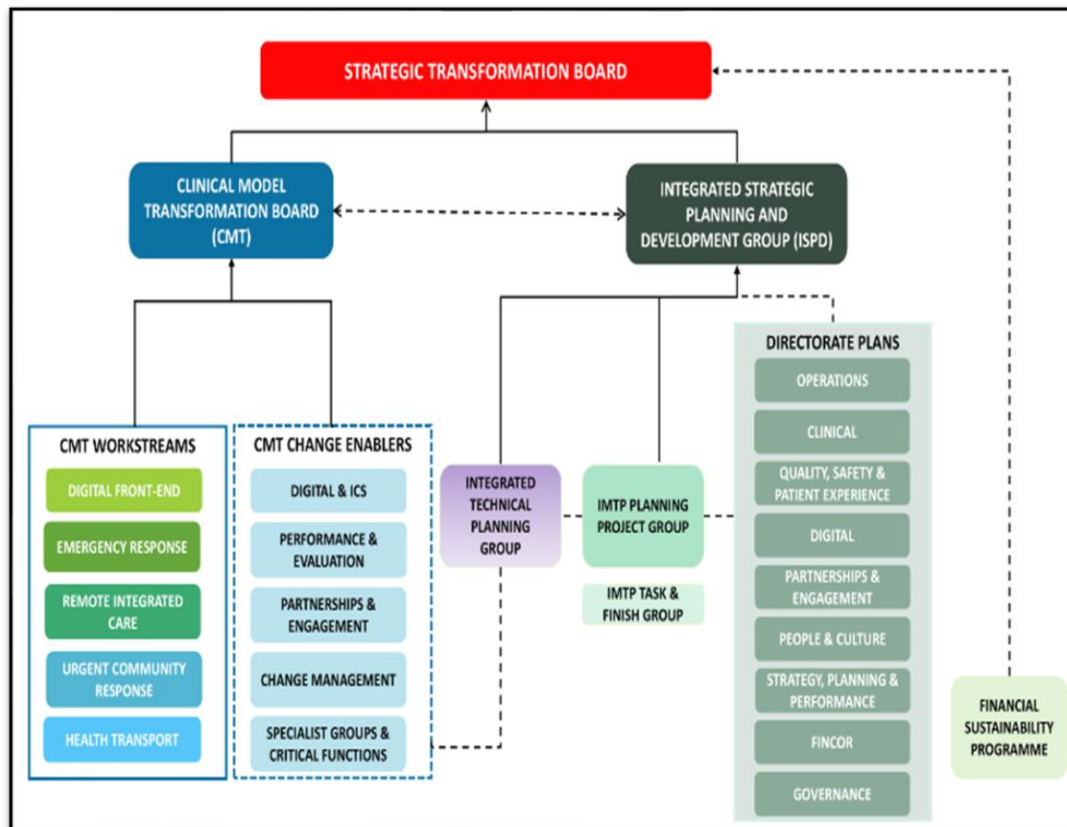
The IPC team continues to lead the review of all WAST IPC policy documents and guidelines. It is essential to ensure these documents are streamlined, up-to-date and provide a clear, evidence based framework for safe and consistent practice.

Documents reviewed in the past year included: -

- PAPR Standard Operating Procedure
- Mpox Policy

1.14 IMTP delivery

The IMTP delivery structure was reviewed in 2024, and previous transformation programmes were brought under the umbrella of a single CMT Programme with wider IMTP actions delivered through directorate plans. Both the CMT and Directorate led IMTP programmes of work report to the STB.



The STB continued to meet regularly (every six weeks) during the year, delivering significant transformation despite the increased operational and financial pressure across NHS Wales across the urgent and emergency care system. The infographic overleaf shows some of the delivery across the breadth of the IMTP throughout 2024/25.

Good progress was made in all areas, including in areas such as digital, estates and fleet. There were some areas that we were not able to achieve, including continued delay to the re-rosters in NEPTS and a demand and capacity review in 111. However, these have now progressed with delivery expected in 2024/5. The development of the 111 website and updated symptom checkers remain a priority but could not be delivered in 2024/25 as funding has not yet been agreed. Key deliverables in 2024/25, however, were the implementation of the new 111 system in April 2024 paving the way for some important changes we are going to make in our CMT programme, and the implementation of Rapid Clinical Screening of 999 calls. The infographic below gives some examples of work completed throughout the year:



1.15 Ministerial Priorities and NHS Wales

Despite financial challenges for NHS Wales in 2023/24, the Trust was expected to deliver its commitments in its IMTP, particularly against the Ministerial priorities that are relevant to the Trust.

Ministerial Priorities

Primary Care and Community Care

The Trust set out its IMTP actions for 111 services and pathways available to 111 and 999. A key change in year was the availability of pathways that were previously available to 111 being made available to 999 remote clinicians. The trust also enhanced its remote clinical skill mix, employing specialist roles such as mental health and pharmacy into its integrated care services across 111 and 999.

During the year the Trust also supported the 6 goals programme in developing the national falls framework and will be developing its falls services in line with this framework.

Throughout the year the Trust also deployed Community Welfare Volunteers who are able to monitor patients and provide observations to 999 remote clinicians to help them determine the most appropriate community or ambulance response for the patient.

Urgent and Emergency Care

The IMTP actions for Urgent and Emergency Care were aligned to the six goals for urgent and emergency care.

Goal 2

The Trust implemented its new CAS system in April 2024, with benefits realisation report shared with commissioners in quarter three. A metrics report is being developed for the Joint Commissioning Committee. Enhancements and development of the 111 website and symptom checkers was delayed in 2024/25 as a funding source had still not been agreed, however this has rolled forward into the Trust's 2025/28 IMTP.

Improving efficiency in 111 rosters to better match capacity to demand commenced with a demand and capacity review, with full re-roster due in 2025/26.

Goal 3

A key development of the Trust's clinical model is remote clinical assessment as a specialty, designed to increase consult and close rates, reducing the need for a conveyance to hospital where safe and appropriate to do so. Progress was made in

paving the way for a remote integrated care services which is planned in the 2025-28 IMTP.

The Trust has plans to improve referrals into Same Day Emergency Care (SDECs), but this remains challenging, but Trust staff continue to engage with the six goals programme to improve access to pathways including SDEC.

Goal 4

A focus for the trust has been increasing production (UHP) in the Cymru High Acuity Response Units (CHARU). UHP increased to 94% nationally. Rural areas continue to be challenging for recruitment into EMS rosters however there has been some improvement in the CHARU lines, particularly in Powys.

The Trust has seen an improvement in sickness absence in EMS and in its contact centres, driven by decrease in long term sickness.

Goals 5 & 6

The Trust introduced a single phone line for hospitals to request transfers, alongside the implementation of new MTPS transfer protocols. However, the development of an all Wales model for transfers and discharge remains challenging. Modelling has shown that there would be an increase in resource required to run a fully ring fenced service and actions within the 2025-28 IMTP will focus on re-engaging with commissioners and partners on rethinking the model going forward.

Planned Care and Cancer Recovery

The roster review in NEPTS has been delayed with demand increasing for NEPTS services. This has had an impact on cancellations and wait times. Working parties for the NEPTS re-roster have commenced in quarter 4 and are a key priority for the Trust in 2025/26.

An enhanced hub for renal and oncology went live in 2024/25 with a work with cancer centre liaison to develop national processes to ensure improvement.

Mental Health

The Trust successfully piloted a mental health response vehicle in Southeast Wales, as part of the development of a wider mental health service. The vehicles have been supported by WAST's own clinicians and therefore running a 7 day roster has been

challenging. However, the integrated remote and on the road mental health service offer remains a priority for the Trust.

NHS Recovery

For the Trust the key metric that indicates the pressure (and state of recovery) of the unscheduled care system in Wales is handover lost hours. The 2019 EMS Demand & Capacity Review was predicated on December 2018 handover lost hours, which were 6,038. In December 2022 the Trust lost 32,098 hours to hospital handover in Wales, which equated to 37% of emergency conveying ambulance production that month.

These levels are extreme and an international outlier. The Trust can take actions to mitigate the impact of handover, but it cannot offset this scale of loss. In 2023/24 some improvement was evident, with average monthly handover, pan-Wales, falling to 21,700. However, during 2024/25 this figure declined slightly once again, increasing to 22,033 lost hours per month.

The increase in handover lost hours seen in 2024/25 did have an impact on performance, in particular, the Amber median, which rose from 1 hour 19 minutes in 2023/24 to 1 hour 53 minutes. The ideal Amber One median should be 18 minutes. It has been identified that there is a strong correlation between handover lost hours and Amber performance. As a result of these extreme levels the Trust has seen a very high level of patient cancellations each month (unmet need) and avoidable harm caused by delayed community responses and delays outside hospitals.

The Trust will continue to take actions within its control: abstractions management, utilisation rates, 'Consult and Close' and 'See and Treat', but handover reduction remains critical. The Ministerial direction to Health Boards for 2024/25 is no handovers of more than one hour, which equates to the 7,500 hours above.

Supporting the Health and Care Workforce

Our newly published Health and Wellbeing Plan 2025/2029 highlights the importance of understanding staff health and wellbeing through a systemic and organisational lens. The Trust has a comprehensive health and wellbeing offer designed to meet the needs of our staff; the Plan sets out how we will develop our wellbeing offer to ensure we are improving the employee experience, including our response to traumatic events at work and continuing health promotion.

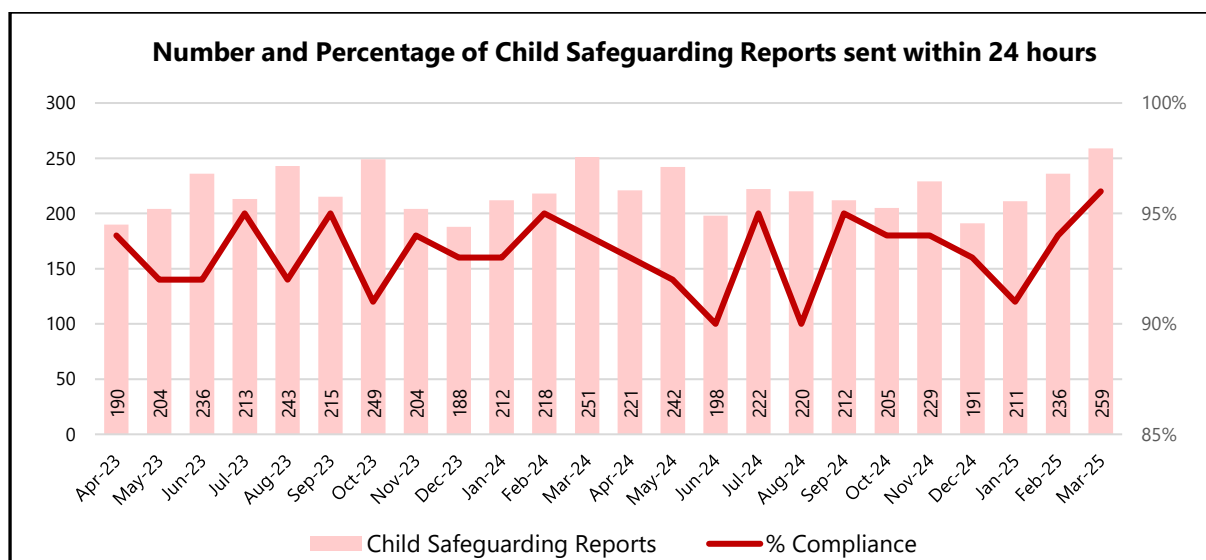
Our People and Culture Plan 2023/2026 outlines our vision and objectives to create a positive and inclusive workplace culture. Our Strategic Workforce Plan lays out our approach to ensuring we have the culture, capability, and capacity to deliver the quality of care our patients expect. We continue with our local approach to the Health Education and Improvement Wales (HEIW) Retention Plan, particularly focused on our nursing workforce; and our Strategic Equality Plan 2024/2028 to drive change, ensuring that the Trust is maintaining a safe and inclusive workplace for its people.

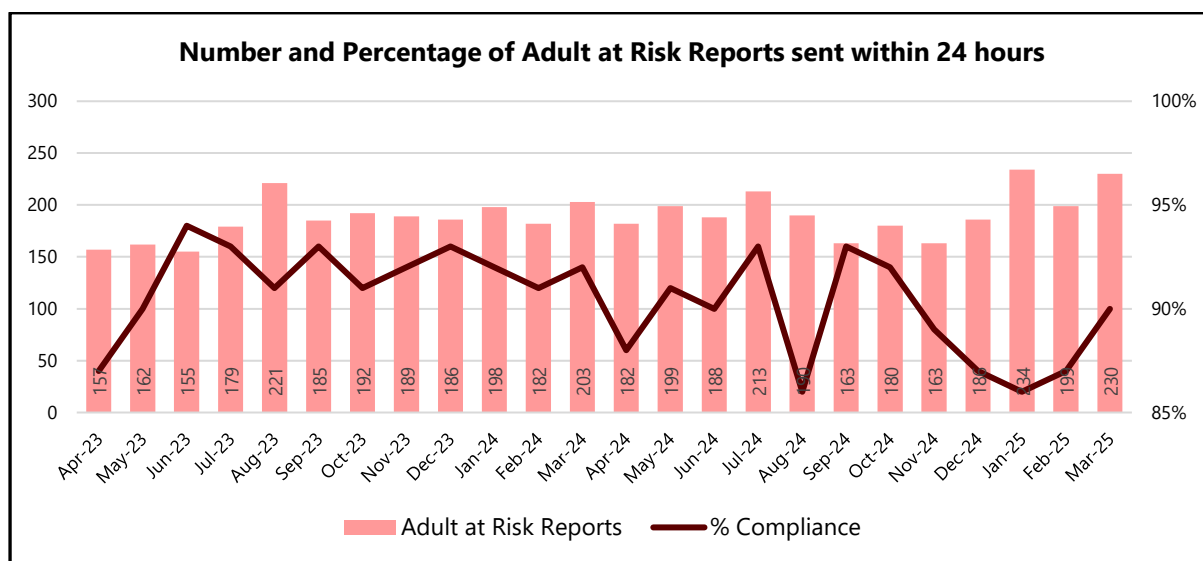
NHS Finance and Managing within Resources

The Trust achieved financial balance in 2023/24. Please see the 'Finance and Value' section of the Performance Report for further narrative.

Working Alongside Social Care

The Trust has considerable contact with the population in their home environments, which means the Trust's people can identify issues for social care. A key area is safeguarding reporting for adults and children. The Trust achieves a high level of reporting within 24 hours and these key metrics are reported to every committee and to every Trust Board.





Falls Service

During 2024/25 falls calls to the Trust have continued to be one of the highest call categories by 'Nature of incident', accounting for over 53,000 calls, 13% of all calls. This equated to a 3.5% increase in falls incidents compared with 2023/24. However, despite the increase in calls, there has been a 1.7% decrease in the number of falls incidents conveyed to hospital. Whilst a modest change, this demonstrates the Trust's ability to reduce conveyance and support its ambition to support care in place and lessen pressure on the wider system.

The Trust currently has 11 dedicated Level 1 'Responder' response resources: eight daytime and three night-time. In addition to two level 2 'Enhanced' falls and Frailty resources in Betsi Cadwaladr University Health Board and Aneurin Bevan University Health Board through Regional Integrated Funding. Whilst our current falls resourcing remains static, utilisation has continued to meet internal targets, and our core resourcing requirements meet Trust Executive approval into 2026.

Our falls response resources have attended 14,000 incidents in 2024/25 supporting over 7,800 people to receive care at home and avoid conveyance to hospital. In areas with developed specialist resource provision, including 24-hour 'Responder' resourcing and an 'Enhanced' resource, there has been a 7% lower rate of conveyance for falls against the Trust National average and over 10% in areas with minimal falls resourcing, reinforcing the imperative need to scale resources nationally and in all Health Board areas.

Community Care and Care Home work remains a Trust and NHS executive priority. There has been increased scale and spread of post falls management in Swansea University Health Board as a result of pilots undertaken in 2023/24, including domiciliary care, residential care and nursing care providers, leading to reduced need of ambulance resources. We are seeking to spread this model to all areas of Wales and engage with partners to support greater community resilience.

Looking forward to 2025/26, the Trust is undoubtedly going to face some financial challenges, however the alignment of our falls plan and the All- Wales Community Falls Framework fosters opportunities for collaboration with key stakeholders and partners to support continued falls response development and achieve an appropriately skilled and timely response to those experiencing a fall, often, our most frail and vulnerable citizens. Essential to the success of care closer to home is further development of Urgent Care pathways in all Health boards and we will continue to support the development of these services with partners.

Mental Health Service

Between 4th November 2024 to 27th March 2025, the Mental Health Clinician (MHC) in remote clinical triage answered 3085 calls, the majority being within the Amber 2 priority category. Of these triaged calls 11% were subsequently conveyed to an ED. From the above calls the MHC identified those that needed to be seen for a mental health assessment in person within the South-East area and the Mental Health Response Vehicle (MHRV) attended to assess the patient. Over the same timeframe the MHRV has attended 393 incidents. The MHRV has conveyed 8% of those patients responded to, to Health Board Mental health services for further assessment.

The Right Care Right Person (RCRP) initiative in Wales is a collaborative approach involving the police and other emergency services to ensure that individuals receive the most appropriate care from the right professionals. All police forces in Wales have implemented stages 1 and 2. South Wales police are the only police force to have implemented all 4 stages.

Trust mental health service have been engaging and working closely with all four police forces on this initiative. A number of partner events have occurred. This collaboration helps in providing timely and effective care.

In Wales, a National Partnership Group has been formed, including various stakeholders, to oversee the implementation of the RCRP initiative and ensure its success. These efforts are designed to improve the response to mental health crisis and ensure that individuals receive the care they need from the most appropriate service. The involvement of Trust mental health service as a core member highlights the significance of their role in influencing and ensuring individuals receive appropriate care.

1.16 Accountability Conditions

The Trust IMTP for 2024/27 was submitted to Welsh Government on 28 March 2024. Welsh Government approved the IMTP subject to accountability conditions on 09 August 2024. The accountability conditions set out the following:

1. Continue with the development of the clinical model, liaising with wider services including health boards, to provide the evidence base and impact expected;
2. Continue to derisk the financial assumptions in the plan to secure the organisation's position; and
3. Ensure delivery is maintained against the commitments within the plan, including ensuring the availability of the detail behind the plan is available if needed.

1. Clinical Model Transformation (CMT) Programme

The CMT programme continues to deliver key enhancements such as rapid clinical screening and the development of remote clinical assessment through its Remote Integrated Care Service (RICS) workstream.

A two-day workshop in January 2025 enabled reflection on progress, strengthened collaboration, and set key priorities for Phase 2, including improved connectivity across Health Care Professional Flows, RICS, Urgent Community Response, and Health Transport. Programme deliverables for FY25/26 were agreed and included in the 2025/28 IMTP.

2. De-risking the financial position

The Trust's IMTP set out a break-even position with a savings target of around £6m. The Trust was able to fully de-risk its plan and delivered a minor surplus at year end.

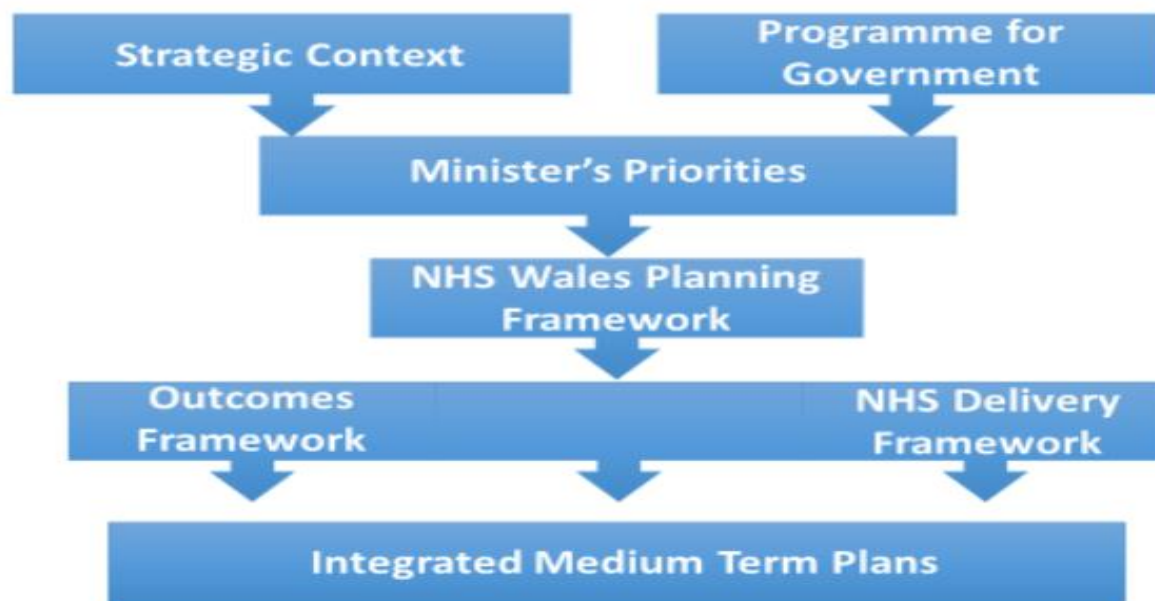
3. Delivery against the IMTP commitments

There was progress against the Trust's IMTP commitments during 2024/25. However, recognising that each IMTP is a three-year rolling plan under the current NHS Planning framework, there have been some programmes of work that have rolled over into 2025/26.

The Trust monitors its IMTP delivery through the Strategic Transformation Board which then reports into Finance & Performance Committee and the Board. These committees have been kept up to date on IMTP delivery confidence and informed where actions will roll over into the next IMTP period.

NHS Wales

The Trust is subject to two key frameworks, the NHS Wales Planning Framework, and the NHS Wales Delivery Framework: -



The 'Ministerial Priorities' have been covered above. The IMTP is a separate document and is publicly available on the Trust's website. For 2024/25 the NHS Wales Delivery Framework identifies the following metrics for the Trust, with the Trust's 2024/25 performance then identified on:

- Percentage of emergency responses to Red calls arriving within (up to and including) eight minutes (65%): the Trust achieved 48.2% in 2024/25 compared to 51.1% in 2023/24. See also the response times sub section of the Our Patients (Quality, Safety and Patient Experience section for further information.
- Median emergency response time to Amber calls: the Trust achieved one hour and 53 minutes in 2024/25 compared to 1 hour and 19 minutes in 2023/24.
- Percentage of sickness absence rate of staff (12 month reduction trend): the average sickness absence rate in 2024/25 was 8.59%, above the 6% IMTP ambition but lower than the 9.29% average rate seen during 2023/24.

- d. Overall turnover rates at the end of 2024/25 was 8.42%, compared to 8.73% at the end of 2023/24.
- e. Percentage headcount by organisation who have had their Personal Appraisal & Development Review (PADR)/medical appraisal in the previous 12 months (85%): as at March 2025, 82.38% of the Trust's staff had received a PADR in the previous 12 months. See also the Our People section for further information.

In addition to the quantitative measures the Trust also undertakes a range of qualitative assessments returns to Welsh Government: -

- dementia care;
- foundational economy;
- learning disabilities;
- strategic equality plan;
- value based healthcare; and
- decarbonisation.

1.17 Workforce Management and Well-being

Staff Well-being

The Trust has a comprehensive health and wellbeing offer. Our clinically led Occupational Health and Wellbeing services support our people to be well at work and performing at their best. Our Occupational Health and Wellbeing Services are clinically led, ensuring the Trust are applying the best evidence in the delivery of our services.

Our Wellbeing Service are highly responsive, offering prompt assessment and signposting to a range of support services both internal and external to the Trust. Our team offer compassionate and validating care shaped to the challenges that our people face. Detailed local knowledge that spans the breadth of Wales supporting our people to access the right support tailored to their individual needs. We offer regular site visits to Clinical Coordination Centres (CCCs), Hospitals and Office Sites across Wales. We support staff and volunteers within the Trust and collate data to identify key themes of concern within the Trust. This year our team have developed

their skills in the assessment and management of suicide risk – ensuring we can identify people at risk and support them to access services. Psychologically informed consultation regarding matters of mental health and wellbeing have been regularly delivered to managers to support staff retention and avoid prolonged sickness.

Our employee assistance programme Health Assured offers a 24-hour support to our people including access to financial advice, legal advice and eight sessions of counselling per difficulty, per year. Health Assured can assess risk of suicide and support access to appropriate services.

In addition, we promote The Ambulance Services Charity 24-hour crisis helpline to those requiring urgent support and advice regarding mental health and suicide risk. Both individuals and managers concerned about someone can access the helpline. We have an online portal that can be accessed from personal devices, as well as within the Trust, called <https://wastkeeptalking.co.uk/>, which provides signposting information to organisations that support the sector. We maintain strong links with these organisations including Canopi – offering brief therapy to NHS Wales staff.

Our Wellbeing Service offers REACT training – an approach to providing peer-to-peer emotional support at work. Supporting our people to navigate important conversations with each other about their wellbeing. REACT sits alongside our Trauma Risk Management network (TRiM), providing an evidence-based response to potentially traumatic events that our people face in the course of their duties. Across 2024/25 there were a total of 1028 offers of support by the TRiM network supporting our people following challenging situations at work. Referral to TRiM can be made by staff or managers. This year we have improved the TRiM assessment process to offer more psychologically informed advice about trauma responses and provide appropriate coping strategies. These improvements have increased engagement in 30-day follow up calls – a key way we identify whether distress requires clinical intervention.

Our services are advertised regularly through many mediums, including posters, leaflets, outreach by the Occupational Health and Wellbeing Team, Intranet, and information regularly passed to managers. There is also a dedicated Occupational Health and Wellbeing Intranet site with up-to-date information on all services available to our people, along with contact details.

In quarter four of 2024/2025 we published the Trust's Health and Wellbeing Plan 2025/2029. The plan provides direction for our health and wellbeing offer throughout the organisation – it was produced in consultation with staff, volunteers and TU partners. The Plan highlights the importance of systemic and organisational interventions, alongside individual focused support; data and evidence-driven interventions; and empowering managers to provide support for our people and provide psychological safety for their teams. Implementation of the new strategy will involve key partners including professional groups within the Trust, trade union partners, Wellbeing and Occupational Health clinicians, external partners, families of serving staff and Trust leadership. The Health and Wellbeing Steering Group will influence and provide ongoing feedback on the plan.

Health and Safety

With respect to Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) reporting; the 2024/25 year continued to be a challenging year for the Trust in regard to ensuring the health, safety, and welfare of its people. Whilst there is a strong level of internal control with respect to metrics provided to the Health and Safety Executive (HSE); there were initial challenges around meeting incident reporting times to the HSE for RIDDOR reportable incidents due to further information within the submission form as amended by the HSE during quarter one 2024/25. This heavily impacted on the Trust's compliance to the timeliness of RIDDOR to the HSE. Despite enhanced levels of focus applied by the function and operational managers the Trust's compliance levels were reduced to 60%. Sustained focus continues to be applied. Safer handling of patients and slip, trips and falls continuing to be highest reported categories.

The health and safety corporate Risk 199, *'Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation'*, was subject to further review in November 2023, with the risk subsequently reduced from 16 to target score of 10 due to several deliverables achieved which provided a greater level of confidence within the Trust. This level was sustained throughout 2024/25.

Diesel Engine Exhaust Emissions (DEEE): Work continued at strategic and local levels throughout the Trust in the reduction of fume exposure. Delays outside emergency departments heavily contributed to a volume of Datix incidents citing ill health effects from potential exposure to diesel engine fumes. This continued to significantly impact on team capacity to complete planned proactive work against the Health and Safety Annual Improvement Plan.

- A further tranche of environmental surveys were undertaken at seven priority sites in 2024/25 and found not to have consistently exceeded the legislative Workplace Exposure Limit as required by the Control of Substances Hazardous to Health (2002) Regulations.
- The Diesel Fume Project implemented the use of bladeless fans for use underneath the canopy area at all seven health board priority sites. The use of these fans negates the need to keep engines running to provide levels of thermal comfort.

Workforce Planning

The Trust currently employs a workforce of approximately 4400 people with the vast majority working on the front line in operational roles such as ACAs, EMTs, our new Emergency Ambulance Practitioner (EAP) post (implemented in November 2024), Paramedics, Senior Paramedics, CHARU and APPs.

In 2024, the Trust produced its Strategic Workforce Plan 2024/2030; the first NHS organisation in Wales to do so. This guiding document outlines our workforce challenges and priorities and includes actions on Welsh Language recruitment, creating volunteering opportunities and developing our internal career pathways.



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Organisationally, we have grown experience and expertise in workforce planning over the years and the team produce detailed workforce data which is used for decision-making, workforce planning and recruitment decisions.

This year has seen the introduction of a Band 5 EAP role which has a wider scope of practice than EMTs which will positively impact on patient experience. Redefining and restructuring the EMS delivery model to maximise the benefits of the EAP Band 5 role within the financial envelope is underway. By upskilling our people and increasing the number of senior clinicians (APPs), on the road, the numbers of patients being transported to Emergency Departments can be reduced.

The development of the Clinical Model Transformation brings further workforce planning work to ensure we have the right people in the right posts with the right skills at the right time and we will need to consider opportunities such as hybrid roles with a mix of road based and centre-based activities. We are consistently and continuously re-shaping and enhancing the workforce to ensure it is fit for the future and financially viable continuing to review the types of posts we need to deliver high quality services to patients and reducing the level of conveyance to hospital.

There are ongoing workforce planning challenges related to the geography of the Principality and appointing to more remote areas. Future thinking will include how we grow people locally and give them access to live and work in their local communities.

Our Integrated Technical Planning Group brings together colleagues across the organisation to work on the holistic picture including clinical skills, education and training, planning, fleet and estate teams to ensure the organisation is taking a co-ordinated approach to its key resources. This supports a cross-functional approach to developing and deploying our workforce to maximise their impact and productivity.

1.18 Decision-making and Governance

Trust's Governance and Accountability Framework

The Trust Board is accountable for governance, risk management and internal control in the organisation. The Board is supported by seven Committees, the particulars of which are in the Accountability Report at Section B of the Annual Governance Statement.

The overarching Trust management governance structure consists of the ELT which is Chaired by the Chief Executive and attended by the Trust's Directors. The ELT is an advisory group which supports the Chief Executive in discharging his accountabilities. The ELT meets weekly for formative discussions, peer support and decision making.

A series of sub-groups report into ELT through an Alert, Advise and Assure (AAA) highlight reporting mechanism including:

- Assistant Directors' Leadership Team;
- Clinical Quality Governance Group;
- Policy Group;
- Pandemic Governance Group;
- National Health and Safety Committee;
- Quality and Performance Management Framework Steering Group;
- Equality, Diversity and Inclusion Steering Group;
- Capital Management Board;
- Executive Finance Group;

As stated above, the STB is the executive group that oversees the development and delivery of the IMTP and is supported by a number of Programme Boards aligned to the IMTP. The Executive Finance Group meets regularly and is comprised of the ELT membership and finance team.

Each Directorate has a governance structure relevant to the size and portfolio of its Director. Further details on the Trust's governance and accountability arrangements, and audit and assurance arrangements are set out in the 'Review of Effectiveness' section within the Annual Governance Statement.

Ambulance Commissioning

A key aspect of the Trust's accountability and governance framework is that the Trust is a commissioned service for 111, EMS and NEPTS. Whilst EMS and NEPTS have been commissioned for some time e.g. EMS started on 01 April 2015, 111 commissioning began in May 2023.

The Trust had separate commissioners for 111 when its commissioning started in May 2023; however, from 01 April 2024 the commissioning for the 111, EMS and NEPTS was brought together into a new NHS organisation, the Joint Commissioning Committee or JCC, as stated earlier in the Performance Report.

Whilst transferring into a new organisation has meant new commissioning governance arrangements for the Trust, in particular, reporting into the new JCC and the new Ambulance & 111 Collaborative Commissioning Group, the basic approach to commissioning has remained unchanged i.e. commissioning frameworks for each of the three services, commissioning intentions for year fiscal year, in year reporting on progress against those intentions and quality and performance metrics, underpinned by a resource envelope (budget). The NEPTS Delivery Assurance Group has remained unchanged and continues to function.

In addition to these governance and accountability mechanisms the Trust also reports bi-monthly to the Integrated Quality, Planning & Delivery (IQPD) and six monthly Joint Executive Team (JET), both of which are NHS Executive accountability mechanisms, which the Director of Ambulance & 111 Commissioning also sits on. The Trust's IMTP is also subject to approval by both the JCC and NHS Executive.

The Trust continued to see support from the JCC in 2024/25 in support of the overall purpose of the emergency ambulance commissioning framework "to shift (patient) demand left, where it is clinically safe and appropriate to do so" i.e. serve the patient demand at the earliest point in the patient journey and serve it once. The JCC supported the recruitment of a further uplift in the Trust's APP establishment (+32 FTEs) and the introduction of Clinical Navigators (+28 FTEs) to support rapid clinical screening.

Further information on the JCC can be found on its website: [Home - NHS Wales Joint Commissioning Committee](#); and further information on the Trust's 999 performance can also be found on the JCC website: [Ambulance Service Indicators - NHS Wales Joint Commissioning Committee](#).

Well-being of Future Generations (Wales) Act 2015

Please refer to the 'Partnerships and System Contribution' section of the Performance Report for the Trust's position and progress on the Well-Being of Future Generations (Wales) Act 2015.

Welsh Language

The Welsh Language Standards, effective from 30 May 2019, have given the organisation the opportunity to improve the level of Welsh language services we provide for our patients, services users, and the wider population.

The Trust continues to strive towards ensuring that the Standards are embedded within its processes and systems to ensure that the Welsh language is treated no less favourably than the English language in its services and operations and that members of the public, and staff are able to interact with the Trust in the language of their choice.

During 2024/25 we have developed a new Welsh Language Policy that describes the steps the Trust will take to: foster a bilingual ethos within the organisation, provide guidance on compliance with the Welsh Language Standards, and the implementation of Welsh Government's 'Mwy na geiriau/More than just words' action plan, with a focus on an active offer of Welsh across our services. To further improve our compliance a Welsh Language Standards baseline has been developed. Within the Trust's Integrated Term Plan (IMTP) 2025/28 our ability to communicate in Welsh with the public and staff will be strengthened via the development of a Welsh language recruitment strategy.

The Trust provides an annual account to the Welsh Language Commissioner on compliance with its Welsh Language Standards under the Welsh Language (Wales) Measure 2011 via an Annual Welsh Language Report, where a range of statistics such as Welsh Language complaints, staff numbers with Welsh Language skills and recruitment numbers requiring Welsh Language can be found.

This report must be published on the Trust's website by the end of September each year, in accordance with Standard 120 of the Regulations.

Sustainability

The Trust is committed to reducing its impact on the environment and supports the Welsh Government's ambition for the public sector to be carbon neutral by 2030. Under the NHS Wales Decarbonisation Strategic Delivery Plan, the Trust is required to support stringent WG environmental targets and key actions in support of these include (but are not limited to) reducing emissions from its estate and fleet as far as possible before 2030. A Decarbonisation Action Plan (DAP) has been produced, detailing actions, action owners and timelines for completion. The DAP is submitted to Welsh Government and updated annually. It is also included as an appendix within the Trusts IMTP, and sustainability is a central theme running through the plan. The delivery of the DAP is overseen by a Decarbonisation Programme Board which reports through internal governance mechanisms to both the Capital Management Board and the Finance and Performance Committee on a regular basis. This Programme Board is supported by a number of workstreams including a specific focus on transportation, and a delivery of Estates Funding Advisory Board funded schemes.

Following current guidance, decarbonisation qualitative and quantitative reports are submitted annually to the Welsh Government detailing carbon reduction progress, challenges, and risks. The Trust also reports on delivery of the DAP to the NHS Wales Shared Services Partnership (NWSSP) Decarbonisation Co-ordination Reporting Team on a regular basis, which informs the work of the National Decarbonisation Programme Board. The Trust's carbon reporting data continues to be reported on an annual basis in line with Welsh Government set methodology and timescales.

1.19 Conclusions and Look Forward

The 2024/25 year has been another challenging year for the Trust with continued high pressure across the health and social care system. There is no doubt that the Trust's staff have again stepped up to the challenge, as have the Trust's partners.

EMS performance has been recognised as challenging for a long time with the Trust still failing to achieve the 65% Red 8-minute target during 2024/25.

We are now in the second year of our ambitious Clinical Model Transformation (CMT) Programme, evolving our Clinical Response Model into an Integrated Clinical Services Model. This transformation is crucial to our strategic objective to provide the right care or advice, in the right place, every time.

The programme represents a fundamental shift in how the Trust will deliver care, transitioning from a conveyance-based emergency response focus to an integrated, patient-centred model that connects our core services into a cohesive system. This approach allows WAST to better meet the healthcare needs of the people of Wales by offering a broader range of care options, including addressing urgent and emergency needs within the community.

Within the 111 service, it has proved a difficult time, with the implementation of the new 111CAS system and the resulting impacts this has had on efficiency and performance. The call abandonment rate monthly average increased to 10.4% during 2024/25, up from 6.2% the year before but now that the system is fully embedded and the service is up to full establishment, it is anticipated that performance will improve over the coming year, dependent on whether the establishment is sufficient to meet the increasing demand, as well as fulfilling its contribution to the new modelling care plan.

Whilst the Trust has stepped up to meet the challenge, patient experience, and safety in 2023/24 continue to not be at the levels the Trust, or its stakeholders, aspire to. The reasons are complex and multiple, with some directly within the Trust's control and others that are not. The Trust continues to work on actions within its control to mitigate this risk including, for example, maintaining high levels of Emergency Ambulance production and fully rolling out the CHARU service.

The Trust recognises that the organisational and broader health system landscape has changed over the past few years. This has placed even greater emphasis on the need for system wide collaboration, developing longer-term solutions that meet the needs of the people of Wales today, and of future generations, focussing on improving clinical outcomes, patient experience and being value driven.

The long-term Strategic Framework for 2030, 'Delivering Excellence', which was agreed in 2019, sets out the Trust's ambition to move from being a traditional ambulance and transport service, to being a trusted provider of out-of-hospital high quality care, ensuring that patients receive the right advice and care, in the right place, every time, with a greater emphasis on providing care closer to home. The Trust's IMTP 2025/28 provides further details on the Trust's strategic plans.

1.20 Links to Further Information

The Trust reports delivery against its IMTP throughout the year and reports on performance to every Trust Board meeting through the MIQPR. For further information and to view these reports please click on the following links: -

Board Date	Board Agenda Item	Link to Trust Board Papers (Public)
30 May 2024	10 and 12	Trust Board Papers – May 2024: ambulance.nhs.wales/files/trust-board-papers/trust-board-agenda-30-may-2024/
25 July 2024	10 and 13	Trust Board Papers – July 2024: ambulance.nhs.wales/files/trust-board-papers/papers-25-july-2024/
26 September 2024	9 and 12	Trust Board Papers – September 2024: ambulance.nhs.wales/files/trust-board-papers/trust-board-papers-26-september-2024/
29 November 2024	10 and 14	Trust Board Papers – November 2024: ambulance.nhs.wales/files/trust-board-papers/trust-board-papers-29-november-2024/
30 January 2025	10 and 13	Trust Board Papers – January 2025: ambulance.nhs.wales/files/trust-board-papers/open-agenda-30-january-2025/
27 March 2025	11, 12 and 13	Trust Board Papers – March 2025: ambulance.nhs.wales/files/trust-board-papers/board-papers-27-march-2025/

Ambulance Service Indicators: each health board receives a performance indicator dashboard, from Welsh Government, to ensure consistent reporting in their annual reports. The Trust is not a Health Board and is a commissioned service by the JCC; consequently, Welsh Government do not issue a dashboard to the Trust. Whilst no dashboard exists, the Trust considers itself a very transparent ambulance service, with the publication of the monthly Ambulance Service Indicators by EASC and Welsh Government, Joint Executive Team (6-monthly) and Integrated Quality, Planning and Delivery meetings (2-monthly).



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Performance Report Contact Details: Should you require any further information on this Performance Report, please contact Hugh Bennett, Assistant Director - Commissioning and Performance on hugh.bennett2@wales.nhs.uk.

PART 2: - ACCOUNTABILITY REPORT

The Accountability Report is intended to meet key accountability requirements to the Welsh Government. The requirements of the Accountability Report are based on the matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of Statutory Instrument 2008 No 410, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2008 No 410.

The requirements of the Companies Act 2006 have been adapted for the public sector context as set out in the Government Financial Reporting Manual (FRoM). It will, therefore, cover such matters as directors' salaries and other payments, governance arrangements and the audit certificate and report. The Accountability Report will be signed and dated by the Accountable Officer. The Accountability Report consists of three main parts. These are:

- **The Corporate Governance Report:** This Report explains the composition and organisation of the Trust's Board and governance structures and how they support the achievement of the Trust's objectives. The Corporate Governance Report itself is in three main parts: the Directors' Report, the Statement of Accounting Officer's Responsibilities, and the Governance Statement.
- **The Remuneration and Staff Report:** The Remuneration and Staff Report contains information about senior managers' remuneration. It will detail salaries and other payments, the Trust's policy on senior managers' remuneration and whether there were any exit payments or other significant awards to current or former senior managers. In addition, the Remuneration and Staff Report sets out the membership of the Trust's Remuneration Committee, and staff information regarding numbers, composition, and sickness absence, together with expenditure on consultancy and off payroll expenditure.

- **Parliamentary Accountability and Audit Report:** The Parliamentary Accountability and Audit Report provides information on such matters as regularity of expenditure, fees and charges, and the audit certificate and report.

2.1 Corporate Governance Report

This Corporate Governance Report details the composition of the Trust's Board and governance structures and how they support the achievement of the Trust's objectives. The report explains the management and control of resources and the extent to which the Trust complies with its own governance requirements, including how the Trust has monitored and evaluated the effectiveness of its governance arrangements. It is intended to bring together in one place matters relating to governance, risk, and control.

The Corporate Governance Report aims to provide the reader with a clear understanding of the organisation and its internal control structure, the stewardship of the organisation and an explanation of the risks the organisation is exposed to. Where there are weaknesses reported in the report, an explanation is provided on how these are being addressed. The Corporate Governance Report consists of three main parts which are:

- The Directors' Report.
- The Statement of Accounting Officer's Responsibilities and Statement of Directors' Responsibilities in Respect of the Accounts.
- The Governance Statement.

2.1.1 The Directors' Report

Where information normally presented in this report is discussed elsewhere in the Annual Report and Accounts, this will be cross-referenced, and the corresponding citation provided.

a) Details of the Chair, Chief Executive and Other Directors

The details of the Chair, Chief Executive, Board Members, Executives and any other individuals who were Directors and have, or had, authority or responsibility for directing and controlling the major activities of the Trust at any point during the year, and up to the date that the Annual Report and Accounts were approved, are provided in the Governance Statement which forms part of this Corporate Governance Report.

The composition of the Trust Board and the names of the Directors forming the Audit, Risk and Assurance Committee (ARAC) are also provided in the Governance Statement. Board Members are listed below, together with in-year changes. Also provided here are any roles board members may have with respect to committees (for example chair or lead), statutory or board champion positions.

Voting Members of the Board 2024/25 as at 31 March 2025

Colin Dennis



Trust Board Chair

Remuneration Committee
Chair

**Rhiannon
Beaumont-Wood**



**Non-Executive Director
(From 11 November 2024)**

Champion for children and
young people

Jayne Beeslee



**Non-Executive Director
(From 19 August 2024)**

Chair of the Finance and
Performance Committee
as of the 01 September
2024, Champion for
digital

Peter Curran



Non-Executive Director

Chair of the Audit, Risk and
Assurance Committee, Chair of
the Charity Committee (from
01 January 2025), Champion
for armed forces and veterans

Bethan Evans



Non-Executive Director

Chair of Quality, Patient
Experience and Safety
Committee
Champion for Welsh
Language, Infection
Prevention & Control, and
Putting Things Right
(Patient Safety)

**Professor Hayley
Hutchings**



**Non-Executive Director
(From 11 November 2024)**

Academic Non-Executive
Director, Champion for
research

Ceri Jackson



**Interim Vice-Chair (Until
30 June 2024) and Vice-
Chair (From 01 July
2024))**

Chair of Charity
Committee (Until 31
December 2024)
Champion for mental
health, older persons and
raising concerns

Hannah Rowan



Non-Executive Director

Chair of the Academic
Partnerships Committee
Champion for equality

Jason Killens 	Chief Executive Officer Accountable Officer	Lee Brooks 	Executive Director of Operations Champion for emergency planning
Rachel Marsh 	Executive Director of Strategy, Planning & Performance Joint Executive Lead for the Finance and Performance Committee	Chris Turley 	Executive Director of Finance and Corporate Resources Joint Executive Lead for Finance and Performance Committee. Executive lead for Audit, Risk and Assurance Committee. Charity Treasurer. Fire safety champion
Liam Williams 	Executive Director of Quality & Nursing Caldicott Guardian Executive Lead for Quality, Patient Experience and Safety Committee Champion for children and young people, putting things right and violence and aggression	Andy Swinburn 	Executive Director of Paramedicine
Non-Voting Members of the Board 2024/25 as at 31 March 2025			
Estelle Hitchon 	Director of Partnerships & Engagement Executive Lead for Academic Partnership Committee and Charity Committee	Carl Kneeshaw 	Director of People (From 01 November 2024) Joint Executive Lead for People and Culture Committee, and Executive Lead for Remuneration Committee

Angela Lewis 	Director of People and Culture (Until 31 October 2024), Director of Culture Change (From 01 November 2024) Joint Executive Lead for People and Culture Committee; Champion for Anti-racist Wales Action Plan	Trish Mills 	Director of Corporate Governance /Board Secretary (Title changed from Board Secretary from 08 March 2024) Champion for Welsh Language
Hugh Parry 	Trade Union Representative at Trust Board	Damon Turner 	Trade Union Representative at Trust Board
Jonny Sammut 	Director of Digital Services Senior Information Risk Officer		

Board Members who left Board positions in-year

Joga Singh 	Non-Executive Director Chair of the Finance and Performance Committee (Until 31 August 2024)	Professor Kevin Davies 	Non-Executive Director (Until 30 September 2024) Champion for armed forces and veterans; mental health

Further to the changes reflected in the above tables, Board member changes made during 2024/25 are set out below. The board skills matrix was updated in 2024/25 with changes to the Board as they occurred. The above and below changes had no detrimental impact on the Board or on collective decision-making; the Board had a full complement of voting members at all times.

- Professor Kevin Davies' tenure as Vice-Chair of the Trust Board was extended from the 31 August 2023 to the 30 November 2023. He stepped down as Vice-Chair effective 30 November 2023 and was further extended in the role as Non-Executive Director from the 01 December 2023 until the 30 September 2024. He left the Board as of the 30 September 2024.
- During the year, the Trust made a strategic adjustment to its People and Culture leadership structure to ensure continued focus on both our broader people agenda and our culture transformation priorities. In October 2024, Angela Lewis transitioned to a part-time, fixed term role as Director of Culture Change, allowing her to dedicate her expertise to driving our cultural transformation work. To maintain strong leadership across all aspects of our people services, Carl Kneeshaw was appointed on a permanent basis as Director of People, overseeing key functions such as Education and Development, Occupational Health and Wellbeing, People Services, Recruitment and Workforce Planning. This temporary arrangement, planned for two years, ensures sustained progress in embedding cultural change whilst maintaining robust people services across the organisation.

In the 2024 Audit Wales Structured Assessment, in reference to Board membership and composition, the following was stated; *"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".*

The members of the Trust's ARAC as at 31 March 2025 were Peter Curran (Chair), Ceri Jackon, and Rhiannon Beaumont-Wood. The membership of the Committee changed in year due to the resignation of Joga Singh and retirement of Kevin Davies, Non-Executive Directors, and a change to the composition across the committees of the Board following new Non-Executive Directors being appointed.

b) Declarations of Interest

The Register of declarations of interest for Directors can be found on the Trust website, [Board Member Register of Interests as at 31 March 2025](#). During the 2024/25 financial year the Trust published the Register of Trust decision-makers, in line with the provisions of the Standards of Business Conduct Policy. The Register can be viewed on the Trust [Publications page](#).

c) Personal Data Related Incidents

Information on personal data related incidents which have been formally reported to the Information Commissioner's Office and "serious untoward incidents" involving data loss or confidentiality breaches are detailed in the Governance Statement, which forms part of this Corporate Governance Report. A principal risk in relation to compliance with Data Protection Legislation is included on the Corporate Risk Register (CRR) at a score of 15 (3x5) and is aligned to the Finance & Performance Committee for oversight.

d) Environmental, Social and Community Issues

The Trust is aware of the potential impact its operation has on the environment, and it is committed to:

- Ensuring compliance with all relevant legislation and Welsh Government Directives.
- Sharing the Welsh Government's ambition for public bodies to be carbon neutral by 2030.
- Working in a manner that protects the environment for future generations by ensuring that long-term and short-term environmental issues are considered.
- Preventing pollution and reducing potential environmental impact; and
- Maintaining its ISO 14001 environmental management accreditation.

The various sections of the Performance Report provides further details of the DAP, the work of the PECL Team and our volunteers during 2024/25. It also details the Trust's involvement in the Regional Partnership Boards and the Trust's Well-being Objectives as part of the Well-being of Future Generations (Wales) Act 2015.

e) Cost Allocation and Charging Requirements

The Directors confirm that they have complied with the cost allocation and charging requirements set out in His Majesty's Treasury guidance.

2.1.2 Statement of Accountable Officer's Responsibilities

The Accountable Officer is required to confirm that, as far as they are aware, there is no relevant audit information of which the Trust's auditors are unaware, and the Accountable Officer has taken all the steps that they ought to have taken to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

The Accountable Officer is also required to confirm that the Annual Report and Accounts as a whole, is fair, balanced, and understandable and that they take personal responsibility for the Annual Report and Accounts and the judgments required for determining that on the whole, it is fair, balanced, and understandable.

Statement

The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer to the Trust.

The relevant responsibilities of Accountable Officer, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

As Accountable Officer, I can confirm that, as far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware and that I have taken all the steps that I ought to have taken to ensure that I and the auditors are aware of relevant audit information.

I can confirm that the Annual Report, and Accounts as a whole, is fair, balanced, and understandable, that I take personal responsibility for the Annual Report and Accounts and the judgement required for determining that it is fair, balanced, and understandable.



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I can confirm that I am responsible for authorising the issue of the financial statements on the date they were certified by the Auditor General for Wales. To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Jason Killens

Chief Executive Officer

Date: 26 June 2025

2.1.3 Statement of Directors' responsibilities in respect of the Accounts

The Directors are required under the National Health Service (Wales) Act 2006 to prepare accounts for each financial year. The Welsh Ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure of the Trust for that period.

In preparing those accounts, the Directors are required to:

- apply on a consistent basis accounting principles laid down by the Welsh Ministers with the approval of the Treasury;
- make judgements and estimates which are responsible and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the account

The Directors confirm that they have complied with the above requirements in preparing the accounts.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the authority and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction by the Welsh Ministers.

By Order of the Board

Signed:

Colin Dennis

Chair of the Trust Board

Date: 26 June 2025



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Welsh Ambulance Services
NHS Trust

Jason Killens

Chief Executive Officer

Date: 26 June 2025

Chris Turley

Executive Director of Finance and Corporate Resources

Date: 26 June 2025

2.1.4 The Governance Statement

This Governance Statement demonstrates how we managed and controlled resources in 2024/25 and the extent to which we complied with our own governance requirements, including how we have monitored and evaluated the effectiveness of these arrangements. In doing so, it brings together all disclosures relating to governance, risk, and control.

a) Scope of Responsibility

The Trust Board is accountable for governance, risk management and internal control in the organisation. The Chief Executive, as Accountable Officer of the Trust, has responsibility for maintaining appropriate governance structures and procedures. This includes ensuring that the Trust has a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst also safeguarding the public funds and the organisation's assets. For the year ended 31 March 2025, and through to the date of approval of the Annual Report and Accounts, these have been carried out in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales.

The ELT assists the Chief Executive in discharging his accountabilities and meets regularly for formative discussions, support and decision making. A similar structure is mirrored in the Assistant Directors' Leadership Team (ADLT).

The Annual Report outlines the different ways the Trust has worked, both internally and with partners, in response to the system pressures in planning and providing services. It explains arrangements for ensuring standards of governance are maintained, risks are identified and mitigated, and assurance has been sought and provided. Where necessary, additional information is provided in the Governance Statement. However, the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Governance Statement.

b) Governance Framework

Governance describes the ways that organisations ensure they are run efficiently and effectively. It also describes the ways organisations are open and accountable to the people they serve for the work they do. For the Trust, good governance is creating a framework within which we:

- Provide our patients with good quality healthcare services.
- Are transparent in the ways we are responsible and accountable for our work.
- Ensure we continually improve the ways we work and demonstrate our commitment to the duty of quality.
- Adhere to principles of good governance and the [Nolan Principles](#).

In 2024 the Trust's name changed to reflect the designation of 'University Trust Status' (UTS). From 01 April 2024 the Trust's name became the Welsh Ambulance Services University NHS Trust. This status demonstrates the Trust's commitment to and formal recognition of the role that it plays in the education and development of ambulance workers and the world-class research that the Trust undertakes to improve public health in Wales.

Ensuring good governance is at the core of how we serve our patients, support our staff, and sustain our organisation. This is reflected in the structures, systems, and processes we establish to manage our responsibilities effectively as well as the behaviours we demonstrate and standards we adhere to. Central to this framework is our people - their dedication, professionalism, and the ethical standards by which they conduct their work play a pivotal role in upholding our governance standards.

Our approach to governance is dynamic, involving continuous scrutiny of our performance and a commitment to the duty of quality. The Trust's integrated governance programme takes a holistic approach to governance that aims to streamline and unify the mechanics and dynamics of governance at the Trust. This involves the application of a set of simplified governance principles to the existing, maturing, and emerging elements of the Trust's governance, accountability, risk, and assurance frameworks. This, coupled with the QPMF supports coherence, efficiency, and accountability at all levels from 'floor to board'.

The Trust's governance framework houses the structures, systems, processes, and behaviours NHS Wales health bodies are required to establish for ensuring good governance, and they include but are not limited to:

- Standing Orders, which incorporates the Scheme of Reservation and Delegation of Powers, and the Standing Financial Instructions.
- The requirement for a unitary Board and the Committees that support the Board, together with their terms of reference.
- How line managers operate, including standards of business conduct and accountability.
- Annual business planning via the Integrated Medium-Term Plan and local directorate plans.
- The Quality and Performance Management Framework.
- Policies and procedural guidance for staff.
- Risk registers and assurance frameworks.
- Internal audit; and
- Scrutiny by external assessors including Audit Wales, the Welsh Government, Health Inspectorate Wales, and other stakeholders.

The Trust has approved Standing Orders for the regulation of its work. These are designed to translate the statutory requirements set out in the NHS (Wales) Act 2006 and the National Health Service Trusts (Membership and Procedure) Regulations 1990 (SI 1990 No. 2024) as amended, into day-to-day operating practice. Together with the Standing Financial Instructions and the Scheme of Reservation and Delegation, they provide the regulatory framework for the business conduct of the Trust and define its ways of working.

The following non-compliance of Standing Orders was reported to the board:

- On 06 March 2025 the ARAC was alerted to the non-compliance with paragraph 7.2.7 of the Standing Orders in respect of the approval of the minutes of the Annual General Meeting (AGM) from 2023. Standing Order 7.2.7 requires that “A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement”. It was identified in Autumn 2024 that this had not been the case for the 2023 AGM minutes (which were taken to the 2024 AGM for approval). This oversight was corrected for the 2024 AGM, and the minutes were approved by the board in November 2024.
- On 06 March 2025, ARAC received an update regarding the non-compliance with the application of the contract award process with respect to digital procurement. The Trust Board received this information directly via correspondence in February 2025, and the committee were advised that whilst the process was followed in line with Standing Orders, the contract was awarded without the required approval of the Board (as the financial limit exceeded the Chief Executive’s delegated financial limit); as such, retrospective approval was sought from the Board. The Board and the Committee were assured of the mitigating actions taken to ensure future compliance.

In May 2024 the Trust Board approved a temporary amendment to Standing Order 7.2.5 which requires the Trust to hold its Annual General Meeting (AGM) no later than the 31 July each year. The temporary amendment was in response to guidance from the Welsh Government which allowed NHS bodies to hold their AGM no later than 30 September 2024. In response, the Trust held its 2024 AGM on the 27 September 2024.

Changes to the Trust's Standing Orders, Scheme of Reservation and Delegation of Powers in year included the following:

- Change in Trust name to reflect UTS from 01 April 2024;
- Changes in the Trust's commissioning arrangements with the establishment of the Joint Commissioning Committee from 01 April 2024;
- Changes to the Scheme of Reservation and Delegations of Powers logistical process that flow from the changes, in relation to contract awards. The Standing Orders and accompanying documents can be found in the [publications](#) section of our website;
- In March 2025 the Board approved changes to the Standing Orders (Main Document) in relation to the publication of papers such that it is now stated that there must be at least five clear days between publication of papers and a meeting of the board. There were other minor changes made regarding nomenclature;
- Additionally in March 2025, there were changes made to the Scheme of Reservation and Delegation of Powers (Schedule 1) to update the titles of Directors within Tables A and B.

Trust Board

The Board is accountable for governance, risk management and internal controls. It focuses on the following key areas:

- Strategy: Developing the strategy, vision, and purpose of the Trust. Identifying priorities, establishing goals and objectives, applying resources, understanding risks to the achievement of objectives, and allocating funds to support the decisions that need to be made around strategic planning.
- Embedding Ethical Behaviour: The Board shapes the culture of the Trust in several ways, including by the way in which it engages with our people, our patients and stakeholders, the way it manages its agenda, by the nature of the discussions at the Board and the relative emphasis given to different performance criteria, by the visibility of its members in the organisation, and by where it chooses to invest time and resources. Board members must live

up to the highest ethical standards of integrity and probity and abide by the Nolan Principles.

- Quality: Sets organisation wide expectations and accountability for high performance and compliance with the duty of quality and the duty of candour as set out in the Health and Care (Quality and Engagement) (Wales) Act 2020. Ensures that all staff understand their role in the effective and high-quality provision of care in a governance framework that ensures a balance between trust, constructive debate, and effective challenge in a culture of openness and learning.
- Managing Risk: The Board is responsible for ensuring there is a robust system of risk management and internal controls in place, and that they are sighted on the mitigations in place for the principal risks to the delivery of the strategy.
- Gaining Assurance on the Delivery of Strategy and Performance: Holding to account, and being held to account, for the delivery of the strategy in accordance with the strategic and performance frameworks developed by the Board, focusing on strategy, performance, culture, and behaviours. Board Members have responsibility for the strategic direction of the Trust, and provide leadership and direction, ensuring sound governance arrangements are in place.

The Board comprises the Chair, Vice Chair, six Non-Executive Directors and six Executive Directors. The Board is supported by five further non-voting Directors and two Trade Union Partner representatives. There were four non-voting members of the Board until 31 October 2024 when this increased to five, with the appointment of Carl Kneeshaw as the Director of People from the 01 November 2024. This change in leadership in the People and Culture Directorate is detailed further in the Directors' Report.

The Board holds scheduled meetings bi-monthly, with an additional meeting to approve the Annual Report and Accounts, and an Annual General Meeting. The Trust Board met in public seven times in 2024/25, and seven times in private session, where matters of confidentiality and/or commercial sensitivity were discussed.

Decisions made in private session of the Board and Committees are thereafter reported in the public session of the Trust Board.

Board and committee meetings in 2024/25 were appropriately constituted and were all quorate. The Trust did not stand down any of the scheduled Board or Board Committee meetings during 2024/25. The Board's sole advisory group, the Welsh Ambulance Services Partnership Team (WASPT) met six times in 2024/25 and reports to the People and Culture Committee.

In accordance with the Public Bodies (Admissions to Meetings) Act 1960, the Trust is required to meet in public and has done so for its 2024/25 Board meetings. All meetings of the Trust Board in 2024/25 were held at the Cardiff Ambulance Station.

Throughout 2024/25, the Committees of the Board were mostly facilitated in a hybrid manner, although some continue to take place virtually over Microsoft Teams. This mode of facilitating meetings is effective given the national remit of the Trust and allows for greater participation from members and attendees located throughout Wales.

To ensure business is conducted in as open and transparent a manner as possible, our people, our patients and stakeholders can join the public Board and Committee meetings and can submit questions prior to the meetings. The Trust Board meetings have been livestreamed on the Trust's Facebook page; however, from March 2025 the Trust moved to facilitating these meetings via Microsoft Townhall which means that the livestreaming function is not available.

The recordings of the meetings are still retained on YouTube and the Trust website for future reference and viewing. It remains possible to register and watch the meeting in real time, as was the case for Zoom webinars. Details of how to join a board or committee meeting are available on the Trust's website [here](#).

Details of Board and Committee meeting dates and member attendance can be found in Appendix one and Appendix two. Agendas and papers for public sessions are published on the Trust's [website](#) seven calendar days before a meeting. The Trust held its 2024 Annual General Meeting via Zoom on 27 September 2024 and the meeting was [livestreamed](#). The meeting was held in September 2024 as opposed to July (as per the Trust's Standing Orders) as it reflected the extended audit timeline for the 2023/24 Annual Report and Accounts.

A key focus of the Board during the year was delivery of performance and quality assurance and improvement, in an environment where the system pressures in the NHS in Wales continued to be a key feature. Further, significant time is committed at the Board and its Committees to discussing the harm which our patients and our people were, and continue to be, exposed to; and in doing so ensuring the Trust is doing all it can to mitigate this. There were also important changes introduced in 2024/25 with the revised clinical model and associated CMT Programme, which was a focus for the Board. Furthermore, this year the Board began receiving reports from the Speaking Up Safely (SUS) Guardian on the Trust's SUS arrangements which have been formalised and improved over the last few years.

Decisions and actions were recorded and maintained in the form of meeting minutes and a supporting action log, both of which are reviewed at each meeting.

Key decisions and significant matters of business which require escalation are made by each Committee to the Trust Board after each Committee meeting in the form of an Alert, Advise, Assure (AAA) report. Examples of the key governance and control matters addressed by the Board during 2024/25 were:

- Audit Wales Annual Report for 2024.
- Audit Wales Structured Assessment 2024.
- Charitable Funds (the Trust's Charity) accounts and annual report.
- Monthly integrated quality and performance reporting aligned to the balanced scorecard of our patients, our people, value, and partnerships.
- Delivery of the 2024/27 Integrated Medium-Term plan and approval of the 2025/28 plan.
- Regular financial performance reports.

- Patient and staff stories.
- Risk and Board Assurance Framework.
- Standing Orders, Scheme of Reservation and Delegation of Powers, Standing Financial Instructions.
- Annual effectiveness reviews and amendments to terms of reference for all Committees.
- The Digital Plan Refresh 2024/2029.
- Speaking Up Safely assurance reports.
- The Quality and Performance Management Framework refresh.
- The Trust's Wellbeing Objectives.
- The Health and Wellbeing Plan 2025/2029.
- Trust Annual Report, accounts, and governance statements.
- The Welsh Language Annual Report and;
- The Duty of Quality Annual Report.

Further details on the working of the Trust Board in 2024/25 can be found on our website [here](#), including the dates of meetings, papers, minutes, and recordings of past meetings. Additionally, the Board has a 'Board Visibility and Engagement – capturing our experience', SOP which it follows, to support their leadership of the Trust. This was reported to the May 2025 Board meeting and can be found [here](#).

The **Board Development Programme** continued in 2024/25 with a focus on understanding, learning and reflection. The six scheduled sessions were well attended and designed to stimulate discussion on strategic initiatives; shape culture and behaviours; strengthen system and partnership working; enhance knowledge of the regulatory environment and allow for more detailed briefing of complex issues ahead of formal meetings. Following commentary in the 2024 Structured Assessment, these sessions also include feedback from Non-Executive Directors on the visits they have made in the previous weeks.

Sessions included:

- Strategic planning.
Wellbeing of Future Generations Act responsibilities.
- Manchester Arena Inquiry recommendations.

- Sessions on the Trust's CMT and remote clinical care.
- Reputation audit and feedback.
- Commercialisation.
- International ambulance practice from Australia, the USA and Canada.
- Duty of quality and duty of candour responsibilities.
- Sessions on the development of the Trust's risk appetite statements.
- Cyber security.
- 'More Than Just Words' Welsh Language framework.
- 2025/28 IMTP development.

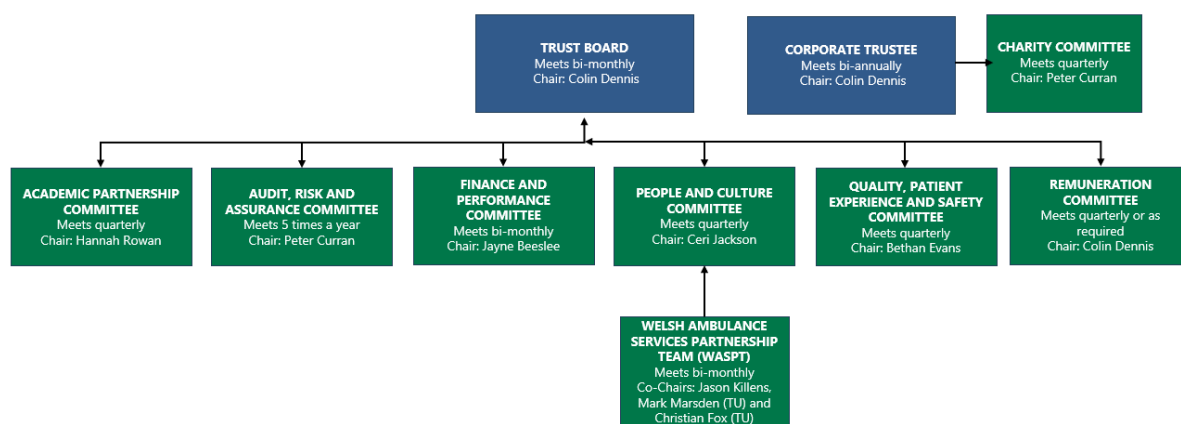
The **Welsh Ambulance Services NHS Trust Charity** (registration number 1050084) is registered as a charity with the Charity Commission for England and Wales. The Trust Board acts as the Corporate Trustee of the Charity. The Corporate Trustee is responsible for the general control, management, and administration of its charity, as well as setting its strategic aims and objectives. Oversight of the Charity is carried out by the Charity Committee. The Charity Annual Report and Accounts for 2023/24 have been published on the Trust website [here](#). The Audit Wales Independent Examination report is available in the Corporate Trustee papers from its meeting in January 2025, available [here](#). The Head of Charity joined in October 2024 to support its strategic development.

Board Committees

The Board has seven standing Board Committees, each chaired by a Non-Executive Director. Committees play an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference.
- gaining assurance and providing oversight on key aspects of organisational performance and supporting achievement of the Trust's strategic goals.
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Committee papers and minutes for each meeting are contained in the [Committee](#) section of the Trust's website. The Board Committee structure is as follows:



Welsh Ambulance Services University NHS Trust

Committee Chairs prepare a highlight report for the Board which is based on an AAA reporting model. This is circulated to the Board following each meeting and discussed at the Board meeting following that Committee meeting. Minutes of Committee meetings are also presented to the Board once approved by the relevant Committee. The Minutes and AAA reports from each Committee are published within 14 days of the meeting. The Minutes and AAA reports from the Charity Committee are taken to the Corporate Trustee where possible.

As well as reporting to the Board, Committees ensure that cross-reporting and consideration takes place, and assurance and advice is provided to the Board and the wider organisation. Each Board Committee has Executive Director or Director leads who work closely with the Chair of that Committee and the Director of Corporate Governance / Board Secretary in agenda setting, business cycle planning and ensuring good quality, timely information is presented to the Committee. After each meeting of the Board and Committees, immediate reflections are sought from the group on the meeting, which often inform changes to operating arrangements.

The terms of reference for each of the Board Committees are set out in the Trust's Standing Orders and a summary of each of the Committee's responsibilities is provided below. The Trust completed comprehensive effectiveness reviews and updates to the terms of reference for each Board Committee during 2024/25.

Each Committee has prepared an annual report of its business and effectiveness in 2024/25, with the annual reports and revised terms of reference for each Committee being presented to the Trust Board in May 2025. The papers for this meeting are available [here](#). It is noted that the name of the Audit Committee was adjusted in year to the ARAC, following the 2023/24 committee effectiveness review.

The **Academic Partnership Committee (APC)**, approaches its remit with a mixture of scrutiny (particularly with respect to refreshed priorities and attainment of UTS, partnering (ensuring the right partners are on the Committee and that appropriate arrangements are in place with partners), connecting (with existing and new partners to research/programmes of work in the Trust, and inquisitorial (drilling down into elements of the priorities and other programmes where we are partnering with academic and industry to foster and promote). In year, the Trust welcomed its first academic Non-Executive Director, Professor Hayley Hutchings, who joined the Trust Board on the 11 November 2024. The committee's effectiveness review this year highlighted the need to view its remit in a fresh light given that University Trust Status has now been confirmed.

The Committee met four times in 2024/25. Through the Committee's cycle of business, a regular stream of assurance was provided as well as updates and matters for discussion and approval. Where necessary the Committee escalated issues of concern to the Board. The Committee's work plan for the year is detailed in the 2024/25 committee annual report, which is available on the public committee page: [here](#). All the committee papers, minutes and highlight reports from throughout the year are also available on this page.

The **Audit, Risk and Assurance Committee (ARAC)** provides key sources of assurance to the Board that the organisation has effective controls in place to manage the risks to achieving its strategic objectives and reviewing governance and assurance processes. The Committee met six times during 2024/25. Through the Committee's cycle of business, a regular stream of assurance was provided as well as updates and matters for discussion and approval. Where necessary the Committee escalated issues of concern to the Board. The Committee's work plan for the year is detailed in the 2024/25 committee annual report, which is available on the public committee page: [here](#). All the committee papers, minutes and highlight reports from throughout the year are also available on this page.

The purpose of the **Charity Committee (CC)** is to make and monitor arrangements for the control and management of the Trust's charitable funds and its strategic direction. The Committee met four times during 2024/25. Through the Committee's cycle of business, a regular stream of assurance was provided as well as updates and matters for discussion and approval. Where necessary the Committee escalated issues of concern to the Board. The Committee's work plan for the year is detailed in the 2024/25 committee annual report, which is available on the public committee page: [here](#). All the committee papers, minutes and highlight reports from throughout the year are also available on this page.

The **Finance and Performance Committee (FPC)** supports the Board by providing assurance regarding the Trust's statutory financial and planning responsibilities and has a monitoring role in the delivery and performance of business functions across the Trust. The Committee met six times during 2024/25. Through the Committee's cycle of business, a regular stream of assurance was provided as well as updates and matters for discussion and approval. Where necessary the Committee escalated issues of concern to the Board. The Committee's work plan for the year is detailed in the 2024/25 committee annual report, which is available on the public committee page: [here](#). All the committee papers, minutes and highlight reports from throughout the year are also available on this page.

The **People and Culture Committee (PCC)** supports the Board by providing assurance with regard to all matters pertaining to its workforce, both paid and volunteer. The Committee provides assurance to the Board of its leadership arrangements, behaviours and culture, training, education and development, equality, diversity and inclusion agenda, and Welsh Language. The Committee met four times during 2024/25. Through the Committee's cycle of business, a regular stream of assurance was provided as well as updates and matters for discussion and approval. Where necessary the Committee escalated issues of concern to the Board. The committee's work plan for the year is detailed in the 2024/25 Committee annual report, which is available on the public committee page: [here](#). All the committee papers, minutes and highlight reports from throughout the year are also available on this page.

The **Quality, Patient Experience and Safety Committee (QuEst)** supports the Trust Board by providing assurance on the Trust's clinical governance arrangements, in particular those for safeguarding and improving the quality and safety of patient centred healthcare. The Committee met four times during 2024/25. Through the Committee's cycle of business, a regular stream of assurance was provided as well as updates and matters for discussion and approval. Where necessary the Committee escalated issues of concern to the Board. The Committee's work plan for the year is detailed in the 2024/25 committee annual report, which is available on the public committee page: [here](#). All the committee papers, minutes and highlight reports from throughout the year are also available on this page.

The **Remuneration Committee (RemCom)** provides advice and assurance to the Board in relation to the Trust's arrangements for the remuneration and terms of service for staff, in particular senior staff. The Committee meets in closed session only and met four times during 2024/25. All the Trust's Non-Executive Directors are members of the Remuneration Committee, and the Chair of the Committee is the Chair of the Trust Board.

Advisory Groups

In support of the Board, the Trust has established the WASPT which is the forum where senior leaders, trade unions and professional organisations work together to improve the Trust's services for the people of Wales. It is the principal partnership forum for the discussion of national priorities and strategies and where Trade Union Partners and senior leaders engage with each other to inform, debate, and seek to agree priorities on workforce and health service issues. This Advisory Group provides the formal mechanism for consultation, negotiation and communication between the trade unions and the Trust's senior leadership.

This Group reports to the PCC at each meeting, with issues escalated to the Board and via the PCC AAA report. WASPT meets bi-monthly and held six meetings in 2024/25 in person and in private session. From May 2024 each meeting included an informal workshop on topical issues.

Operational and corporate forums have been established by WASPT that report into it to enable issues to be dealt with locally, and for WASPT to function in a more strategic space. The Group held its effectiveness review in March 2025 and its terms of reference and annual report will be reported to the Board in May 2025 with appropriate changes proposed to its operating arrangements.

The Trust does not have a Stakeholder Reference group or a Healthcare Professionals' forum (as defined in the IFRS NHS Wales Manual for Accounts) as these are not applicable to the Trust.

Joint and All-Wales Committees

As of 01 April 2024, the NHS Wales Joint Commissioning Committee (JCC) replaced both the National Collaborative Commissioning Unit (NCCU) and the Welsh Health Specialised Services Committee (WHSSC).

The JCC is a joint committee of the seven Health Boards, and it has responsibility for the planning and commissioning of emergency ambulance services including NHS Wales 111 and specialised services which were previously provided by WHSSC, on an All-Wales basis.

Further information on the JCC and its commissioning role is set out in the Performance Report, in particular, the changes to commissioning arrangements effective April 2024. Further information can be found within the 'Decision-making and governance' section of the Performance Report.

The NHS Wales Shared Services Partnership Committee (NWSSP) was established in 2012 and is hosted by Velindre NHS Trust. It has responsibility for the shared functions for NHS Wales, such as procurement, recruitment, and legal services. Regular activity reports of the Committee are received by the Board. The Trust's Executive Director of Finance and Corporate Resources is a member of this Committee. Reports from these Committees were included in Board packs in 2024/25, where available.

Improvements to the Governance Framework

The Trust Board routinely assesses the effectiveness of its governance arrangements, of which the Board's Committees are an integral element. Changes to operating arrangements following the annual Committee effectiveness reviews will be proposed to the Board in May 2025. The full list of changes to operating arrangements is available in the papers for the May 2025 Trust Board meeting, available [here](#).

The changes identified following the 2023/24 annual effectiveness reviews were completed throughout 2024/25 and this was reported to the ARAC in May 2025. Whilst good progress was made, the issue of the Board holding its meetings in venues around the country will be considered further, as it was not implemented in 2024/25.

With specific reference to the ARAC, throughout the year the Non-Executive Director members of the Committee, with the Director of Finance and Corporate Resources and the Director of Corporate Governance/Board Secretary, met quarterly to review the National Audit Office toolkit questions which formed the basis of the Committee's the annual effectiveness review discussions.

c) The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised, the impact should they be realised, and to manage them efficiently, effectively, and economically.

The system of internal control remains in place for the year ended 31 March 2025 and up to the date of approval of the Annual Report and Accounts.

d) Capacity to handle risk

The Trust is committed to actively and effectively managing risk as a key element in the successful delivery of its business and strategic objectives, service provision to the public and remains committed to ensuring staff throughout the organisation are trained and equipped to identify, analyse, evaluate, treat, and escalate risks.

Managing risk is a key, collective responsibility for the Trust Board and remains an integral part of the governance arrangements and organisational activities to support decision making, strengthen and positively impact the development of the Trust's future strategic ambition. It provides clarity on the risks that would prevent us from achieving our organisational objectives.

Risk Management Framework

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring that the Trust has an effective risk management framework and system of internal control in place as required by Standing Orders; however, Directors have responsibility for the ownership and management of corporate and operational risks within their own portfolios.

The Director of Corporate Governance / Board Secretary has responsibility for leading on the design, development and implementation of the Risk Management and Board Assurance Framework (BAF) that provides a line of sight to the controls and related assurances, and the actions the Trust will take to mitigate the risks.

Board Assurance Framework

The Trust's current BAF is mapped to the IMTP deliverables and, by extension, to the strategic objectives. The link to the BAF and the risk report discussed at the Trust Board on 27 March 2025 can be found [here](#). The goal of the strategic BAF is to provide assurance to the Board that the key risks to the strategic objectives are being managed effectively.

The 2024 Audit Wales Structured Assessment noted that *"the Trust is undertaking a significant programme of work to strengthen its risk management arrangements, including enhancing the BAF to ensure it focuses more on the risks to achieving strategic objectives"*.

Internal Audit undertook its annual, planned audit on risk management in Quarter four 2024/25, with the overall objective to assess the effectiveness of the procedures for identification, management and reporting of strategic and key operational risk through the BAF and the Corporate Risk Register (CRR). The review provided reasonable assurance and noted the development of the new strategic BAF that will focus more explicitly on the achievement of strategic objectives and that the reporting of the current key risks through the Board and its Committees is working effectively. The report highlighted one medium priority recommendation to revise and update the Risk Management Framework procedures and documents once the new strategic BAF has been finalised and introduced and the risk appetite statements finalised.

During 2024/25 the Trust continued to make progress on its ambition to develop and deliver a strategic risk management framework as a key enabler of our long-term strategy and decision making. The continued maturation of the risk management framework supports the Trust to focus on whether mitigating actions are taken and achieving their intended impact on significant and ongoing risks and challenges, and to support the Board to challenge where that impact is not being demonstrated or sustained. A specific focus continues to ensure that risks achieve their target score by way of regular review of controls, assurances, and any gaps.

Development of the strategic BAF and risk appetite statements will continue to be overseen by the ARAC in 2025/26.

Monitoring and Recording Risks

Processes are in place for the recording and monitoring of risks throughout the Trust; however, a new digital solution that supports our enterprise risk management, strategic risk management, and the production of a digital BAF is being sought.

The frequency of monitoring risks and the levels of escalation are set out in the Risk Management Guidelines which support the delivery of the Risk Management Policy and enables lower rated risks to be managed locally by the risk owner and delegated officers, teams, and managers best placed to mitigate them. These documents describe the Trust's processes to assess and treat risk through local, Directorate and Corporate Risk Registers. These enable risk owners to apply appropriate inherent, current and target risk scores using a 5 x 5 matrix for likelihood and consequence which was adopted as a best practice framework across Wales.

A BAF guidance document supports the Board in interpreting the component parts of the BAF and the questions they ask to seek appropriate levels of assurance.

Risk Appetite

The Trust operates as part of a publicly funded healthcare system in Wales and does not have unlimited resources, therefore it determines the appropriateness and cost of resources required to address corporate risks.

To be more specific in relation to the appetite for risk against each of our strategic objectives, work began on developing a suite of risk appetite statements in 2024/25 with the Trust Board. These statements 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.

Risk Profile

The risk profile of the Trust is subject to senior management and Board scrutiny. As at the 27 March 2025 Board meeting there were thirteen organisational wide, corporate risks on the Trust's CRR with ten scoring 15 and above.

The Trust's highest rated risks, ID 223 (*the Trust's inability to reach patients in the community causing patient harm and death*), and 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*), remain at the highest score of 25 and remain unchanged despite a series of mitigating actions being in place and several updates to the controls. The number of lost hours due to handover delays remained significant reported at 18,811 hours in February 2025 and 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.

Sustained, and extreme pressure across the Welsh NHS urgent and emergency care system is negatively impacting on patient flow leading to avoidable patient harm and death. Internal and external factors are putting services under severe pressure which presents risks to patient safety.

The Trust's risks continue to be dynamically reviewed in conjunction with one another and closely monitored by management, Board Committees, and the Trust Board as well as at internal forums.

The risk score for the two highest rated risks above 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.

As reported to the March 2025 Trust Board, whilst good progress has been made on the actions that the Trust can control, the extreme pressure continues. Because of this, the likelihood is that the levels of avoidable harm will continue. The Trust is continually seeking additional actions to mitigate these risks, with particular emphasis on the clinical model transformation programme. The actions for the Trust and stakeholders are articulated in the avoidable harm paper that the Board considers at every meeting.

To support the continued, detailed review and mitigation of these highest scoring risks, several workshops took place throughout 2024/25 with members of the Risk Owner's senior teams to contribute to the design and development of a different approach to managing and monitoring those areas that are within the Trust's control and those that are not. This work continues into 2025/26.

The BAF provides detail of mitigating actions for all principal risks, and these are updated when risks are reviewed according to the review schedule. The ten organisational corporate risks scoring 15 and above are described in the table below.

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)

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
201 PCC	A loss of stakeholder confidence that damages the Trust's reputation.	IF there is an inability of the Trust to deliver its core services because of system or organisational pressures THEN there will be a loss of stakeholder confidence in the Trust RESULTING IN a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny	Director of Partnerships & Engagement	20 (4x5)
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	20 (4x5)
641 FPC	The Trust's inability to implement the learning from all relevant Manchester	IF the Trust has not fully implemented the MAI recommendations AND a major	Executive Director of Operations	20 (4x4)

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
	Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	incident or mass casualty incident is declared THEN there is a RISK that the Trust's Incident Response will be suboptimal RESULTING IN avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability		
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)
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	Director of People & Culture	15 (3x5)

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm		
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)
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	Director of Digital Services	15 (3x5)

CORPORATE RISK REGISTER				
RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		RESULTING IN unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.		

Risk Assessment and Risk Review Process

The Trust's ADLT, ELT, ARAC and Trust Board regularly received, considered, and contributed to the CRR during 2024/2025. Furthermore, risks relevant to the remit of the Finance and Performance, People and Culture, Quality, Patient Experience and Safety, and the Charity Committees were reported at their meetings for scrutiny and challenge. Each Committee agenda is developed and aligned to risks within its remit and deep dives on mitigations of risks feature regularly for detailed discussion. In addition, the Board receives a stand-alone report on all corporate risks at every meeting focussing particularly on the highest rated risks. These risks are described in the above CRR table.

On each occasion, assurance was provided on progress made by the Trust (including partners and stakeholders as appropriate) to mitigate existing risks and to set out all new and emerging risks to the organisation. The Board and its committees continuously seek to ensure that management is scrutinising the mitigations within its control and that all is being done to mitigate risks to target.

The ADLT continue to review the risk assessments on all new corporate risks in development and any changes to existing risks and mitigating actions. Each of these risks have been developed by the delegated, responsible officers and the risk owners and are agreed at directorate business meetings and signed off by the risk owner prior to review by the ADLT. The activity is then reported to the ELT, for approval, and onwards to relevant Board Committees and the Trust Board.

Stakeholder Involvement in Risk Management

The Trust recognises that managing several of its key risks relies on close partnership working with stakeholders, including Health Boards to ensure risks are understood and mitigating actions are carried out in partnership where necessary. Risk ID 223 and 224 (set out above) require close involvement from system partners to support the mitigation of these highly rated risks.

The Committee Secretary & Associate Director of Corporate Services and the Assurance & Risk Officer from the JCC attended the QuEst meeting in February 2025 to consider the Trust's approach to these highest rated risks, how the committee meeting agendas are structured and how the reports it receives demonstrates the mitigations against these risks. The Trust's risk team have continued to meet with colleagues from the JCC to explore approaches to mitigating these risks from a system perspective given these remain the highest scoring risks on the JCC's new risk register as well.

The highest scoring risks are regularly shared and discussed at the regular Joint Executive Team meetings.

The Trust receives information from a variety of other sources which helps inform the Trust's risks and mitigating actions. These sources include (but are not limited to) feedback from patients and the public, concerns raised with the Trust and serious adverse incidents.

Working with partner organisations is a prominent factor in delivering the Trust's services and ambitions as set out in the IMTP which will result in significant benefits for the population. However, in doing so, the Trust recognises that this will impact on the environment where services and projects are delivered and can lead to additional partnership and programme risks.

Risk Management Training

The Trust remains committed to continuing to deliver risk training, with bespoke training sessions, offered for teams and for specific staff group induction programmes.

The training captures the fundamentals of risk management including the identification and escalation of risk as well as discussion on the Trust's highest scoring risks and the role all staff have in risk management and mitigating specific risks.

Risk Management Programme – Focus for 2025/26

The Trust embarked upon a three year risk management transformation programme in 2022/23 to further strengthen and positively impact the development of the Trust's future strategic ambition and provide clarity on the risks that would prevent us from achieving our organisational objectives.

The programme has built on the positive risk culture embedded during 2022/23 and has, to date, delivered on the re-articulation of the Trust's principal risks; a methodology which has since been implemented across all tiers of risks, the development of the Trust's first Risk Management Policy alongside a suite of procedures, and the introduction of a transitional BAF which is the document reviewed by the Board and its committees currently.

The next stage is the design and implementation the strategic BAF and risk appetite statements. This is in addition to the continued development and roll out of organisational wide training which will bring the risk management transformational change programme to a conclusion.

Emergency Preparedness and Specialist Operations

As a Category One NHS organisation, under the Civil Contingencies Act 2004, the Trust has ensured that we have maintained emergency plans and business continuity arrangements through 2024/25, that consider our duties under the Act and under the NHS Wales Emergency Planning Core Guidance issued by the Welsh Government.

The last twelve months has seen some extensive work within the Emergency Preparedness, Resilience and Response (EPRR) Team, which has included working with internal and external stakeholders on the Manchester Arena Inquiry (MAI) recommendations and working with Welsh Government colleagues on the structure of Welsh Civil Contingency response going forward.

Work has been ongoing to review the recommendations within the MAI report. Following the submission of a funding ask into the JCC, in line with recommendation 106 of the MAI report, the JCC have started to review the reports in conjunction with health board colleagues, utilising four workshops. The outcome of these workshops will then be reviewed for final approval on the funding. To ensure the progress of the recommendations that requires additional funding to complete, beyond the life of the Manchester EPRR project, the 18 recommendations have been developed into a Corporate Risk and will be managed through this process until they can be completed.

The Grenfell Reports have been published and the EPRR Team have reviewed these reports for relevance to the Trust. The EPRR Team have undertaken the review of the two Grenfell reports to assess the recommendations that have been presented and compare the recommendations to the MAI recommendations. The review found no additional recommendations that the Trust should consider, and that our review complemented the work that has already been undertaken on the MAI and passed to our commissioners. Our Grenfell consideration was subsequently submitted to our commissioners.

The EPRR Team has recognised that the Trust obligations under the Civil Contingency Act to ensure robust Business Continuity plans are in place, has needed bolstering. The Trust business continuity reporting structure has been reviewed and updated to provide a consistent reporting and escalation process for all areas of the Trust. This will ensure effective Business Impact Analysis and Business Continuity Plans are in place. To complement the new structure, business continuity software has been procured. This software will allow all departments of the Trust to maintain their plans in a consistent and usable format. Work has commenced to implement the software across the Trust.

The Trust has seen a number of significant incidents, including the train crash in Powys, national loss of our primary telephone systems, the school stabbing in Ammanford and severe weather including the Red Weather Warning affecting large areas of the Trust. These events have enabled the Trust to test its planning and preparation and its response to spontaneous and expected incidents.

The Trust has continued to work with Local Resilience Forum (LRF) partners in reviewing national and local risks. Welsh Government has published a Wales specific risk register looking at the national UK risks and the Wales specific risks. Work is underway with health and LRF partners to assess these risks and mitigate against them. The EPRR team is reviewing the Welsh Risk Register to ensure the Trust is able to mitigate the risks that are applicable to the Trust.

The Trust has sustained a Hazardous Area Response Team (HART) and Specialist Operational Response Team (SORT) response throughout the year. Funding to enhance the Trust's SORT capability has been received; this will allow the Trust to ensure the most effective response to chemical, biological, radiological and nuclear /hazardous material, major terrorist attacks, and water incidents. The first phase of the uplift has been implemented and training for the new volunteer SORT operatives commences in April 2025.

The Trust has continued to work in partnership, through LRF, to address and mitigate the wider impacts of risks on the population and our organisation. We have been key members of the four Local Resilience Fora Executive planning groups, training and co-ordination groups and the Local Resilience Fora subgroups. The Trust has been fully engaged, alongside partners, in the Civil Contingencies Review that has been undertaken across Wales and continues to support Welsh Government and the LRF with the development of the Wales Resilience Framework.

The 2025/26 year will present challenges to the organisation within the emergency preparedness field. Work on the MAI recommendations has highlighted areas of the EPRR Team that need greater capacity, but this can only be achieved with additional funding. The EPRR Team will continue to work with partners from the Blue Light Services and the LRF across Wales and with partners from ambulance services across

the UK to provide as robust an emergency planning function as possible. Further work will be required to implement the recommendations within the MAI reports, and additional funding will be required in all remaining outstanding areas to be able to effectively implement the recommendations.

The UK Government Resilience Framework was released in December 2022 and Welsh Government are currently working on the Wales Resilience Framework which considers that Part One of the Civil Contingencies Act 2004 is devolved to Wales; this report is expected in Spring 2025. This will undoubtedly impact on the Wales Civil Contingencies arena and lead to changes within the emergency planning for all Category One Responders within Wales. The Trust continues to engage and support at a national and local level to remain prepared to respond to any likely event, incident or set of circumstances that impacts on the organisation and population.

e) The Control Framework

Quality Governance Arrangements

The Trust remains focussed on sustaining and developing a culture of improving quality across the Trust with regular reporting of quality governance providing assurance to the QuEST Committee. In September 2024 Audit Wales concluded a follow-up review of the Quality Governance audit conducted in 2022. The key findings acknowledged improvements in our quality governance structures, including compliance with the duties of quality and candour. The review identified a number of recommendations made in the 2022 audit to remain in progress, in contradiction to the Trust's assessment, and areas for further improvement were also identified. The Executive Leadership has provided guidance on the clarity required for governance and evidence required to complete actions to prevent a recurrence of differing levels for future reviews and we have agreed further actions to be taken forward in 2025/26.

An internal quality forum, the QMG, has continued to build connections to support an organisational approach to quality improvement and underpin our Quality Management System. The development of intelligence platforms within this area has allowed us to identify areas of improvement in our quality control and quality assurance spaces working together to share information and monitor improvement.

The purpose of the forum is to improve cross-organisational working and provide advice for strategic forums, through quality planning and escalation, and through assurance governance frameworks. The QMG reports to the CQGG, which is the primary clinical & quality governance forum in the Trust.

Quality Impact Assessments (QIA) are embedded within governance infrastructures and have been pivotal in ensuring that decisions taken around Clinical Services transformation have been considered across the 12 Health & Care Quality Standards. Clear guidance and support is provided across governance forums to ensure that quality is at the heart of decision making and specialist advice continues to be provided by our quality teams to support leaders across the organisation in considering the impacts of proposals and decisions against these standards.

The QPMF provides the principles and organisational requirements for a robust Quality Management System. This framework and the workplan associated with it is monitored by the Quality and Performance Management Steering Group who provide assurance to our Executive Leadership team. The QPMF has been reviewed this year using the clauses and principles of ISO 9001:2015 as a guiding framework. As part of the refresh a stronger influence from the Duty of Quality and the Health and Care Quality Standards 2023 is included throughout. An internal audit completed in November 2024 reviewed the deployment of the framework and assessed the extent to which it is embedded across the organisation. The audit provided reasonable assurance on its findings but identified some areas for improvement relating to the communication plan and governance structure. Because of this, the Trust has agreed further actions to take forward into 2025/26.

A Health and Care Quality standards self-assessment framework has been designed to understand how we are delivering a quality service across the organisation and what improvements we need to make. This framework is used to assess the organisation against the standards, provide assurance to the Quality, Patient Experience and Safety committee and inform the content for the Duty of Quality Annual Report.



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

The Trust's PECI Team provides opportunities for people to share their experience using a face-to-face engagement events, online surveys and storytelling video booth for people to record their own experience stories. Patient stories are shared throughout our governance infrastructure including QuEST and Trust Board with associated evidence of learning and improvement. Throughout 2024/25 we have continued to develop and promote our People and Community Network to offer our citizens the forum to become more involved in improving our services. We have had a concerted focus on integrating peoples' experience feedback using insights from experience data to drive quality improvement. We have worked to increase the visibility of outputs from peoples' feedback through the Trust's QMG.

As part of our quality governance structures it is also important to listen to the voice of our people and identify areas of significant concern for our workforce. We are continuing to work on three specific priorities identified as important to our people through improving flexible working models for our frontline colleagues, eradicating shift overruns through co-produced solutions and improving our people's digital experience. We are committed to amplifying the voices of our colleagues through Speaking Up Safely, our Staff Survey and by continuing to strengthen our internal capacity to drive culture change, harnessing the passion and energy of our flourishing people networks. Feedback from our People Network members is confirming that these communities are offering a safe and supportive place for our staff to come together and share experiences.

The quarterly Putting Things Right report continues to provide assurance to QuEST. This report has a revised format focusing on assurance, performance and learning with an enhanced suite of metrics underpinning each of these areas. Compliance with the Duty of Candour is included within this report, shining a light on our approach to 'working in the open', being transparent, and our ability to be equally open when things don't go well. The statutory nature of the Duty of Candour enhances assurance and visibility of this important aspect of organisational culture. A twice-yearly Learning from Mortality report has been introduced to provide QuEST with further assurance. This report documents the Trust's maturity journey in embedding the Mortality Review Framework and broadening the range of mortality intelligence from which we learn and improve during the Learning from Death forum.

In March, the Public Services Ombudsman for Wales published two public interest reports into our care and treatment of two patients. These reports identified areas for improvement in the standard of call handling, clinical advice and record keeping. The organisation worked closely with the ombudsman over many months to maximise the learning from these events and have already implemented a number of the measures that were agreed.

The health and safety of our workforce is a continued area of focus. A review of adverse incidents reported by our people was undertaken by our Manual Handling advisor. As a result of this review a number of workstreams have been identified to improve the health and wellbeing of our people with activities planned to be taken forward through 2025.

During the 2024/25 period the Quality, Safety and Patient Experience Directorate has undertaken organisational structure changes. In the Quality Governance area, the team and leadership structures have been reviewed to better align our Quality Improvement and Quality Assurance teams to support the delivery of a robust Quality Management System across the organisation.

Information Governance Arrangements (including Data Security)

Information Governance underpins the Trust's ability to deliver high-quality, safe, and effective care. Ensuring the confidentiality, integrity, and availability of information is fundamental to maintaining trust, supporting digital transformation, and complying with statutory responsibilities.

The Trust operates a robust Information Governance Framework and has a statutory responsibility to ensure that effective governance controls and arrangements are in place, to ensure its information processing is in accordance with the law and associated standards. The framework consists of an established suite of information governance, data protection, and information security policies, procedures, guidance, and processes to inform and guide the organisation to ensure compliance is met in practice. The framework includes monitoring and reporting arrangements, audits, compliance assessments, and improvement initiatives along with incident and risk management processes. The Trust has embedded a culture of continuous

improvement across its Information Governance activities, supported by both internal and external audits. Recommendations from these audits are tracked to completion and used to inform policy updates and training content.

Information security remains a significant risk across NHS Wales, and the Trust continues to develop mitigations for and monitor the associated Risk, number 260 '*A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems*'. With a risk-led approach, the Trust has focused on improving the technology, processes, and people aspects to ensure cyber resilience. A Cyber Improvement Plan is in place and is actively monitored. System risk assessments are routinely undertaken. An Information Security Policy is in place, and training and awareness is actively shared and communicated across the Trust under the Information Security Training Campaign. Regular exercises are conducted to test resilience, refine business continuity plans and staff awareness of cyber threats.

An Information Governance Steering Group is established with Executive and senior level membership including the Senior Information Risk Owner, Data Protection Officer, and Caldicott Guardian. The Group receives reports on information governance and data protection matters, developments, and performance. It reports directly to the ELT monthly and provides assurance on the Trust's compliance with relevant Information Governance standards. The FPC has overall oversight of information governance from the QuEST, effective April 2024.

The Trust continues to provide annual submissions to the Welsh Information Governance Toolkit. The Welsh Information Governance Toolkit is a self-assessment tool that enables organisations to measure their level of compliance against national Information Governance standards and legislation. Following the previous year's submission, an Improvement Action Plan was developed by the Information Governance Team to improve on the Trust's compliance with the standards. The progress of the Improvement Action Plan is monitored by the Information Governance Steering Group. For the March 2025 submission, 95% of the improvement actions were completed.

The results of the March 2025 submission are that the Trust met the Minimum Expectations of 10 out of 11 categories. Of the categories that met the Minimum Expectations, six met the Expectations Exceeded standard. The Trust did not meet the Minimum Expectations of the 'Training and Awareness' standard. The Information Governance Team will produce the next iteration of the Improvement Action Plan to target Training and Awareness, as well as the new requirements for the Video Surveillance and CCTV category. The Improvement Action Plan will continue to be monitored by the Information Governance Steering Group.

A new Risk, number 623 '*Failure to comply with Data Protection Legislation*' was included on the Corporate Risk Register in April 2024. The risk and mitigation actions continue to be monitored and managed, including the recruitment into Data Protection Officer and Data Protection Compliance Manager vacancies, as well as continued work on the IG Toolkit Improvement Action Plan during the reporting period.

Data Protection Impact Assessments (DPIAs) are routinely conducted for new or significantly changed systems and processes involving personal data, with support from the Information Governance Team to ensure proportionality and legal compliance.

The Trust uses the Once for Wales Concerns Management System to capture information governance incidents via the incident reporting module. Reported information governance incidents are reviewed and assessed in accordance with the NHS Wales Guidelines on the Categorisation and Notification of Personal Data Breaches, which provides detailed guidance for assessing and reporting incidents. Any remedial actions are taken where required. Incident figures are reported to the Information Governance Steering Group and as part of the Monthly Integrated Quality and Performance Report. Depending on the nature and severity of the incident, the incident reports may be required to be notified to the ICO. During the reporting period (01 April 2024 to 31 March 2025), three incidents were notified to the ICO. Following notification, each incident has been closed with no further action taken by the ICO.

Corporate Governance Code Compliance

An assessment against the Corporate Governance in Central Government Departments: Code of Good Practice 2017, has been completed using the “Comply” or “Explain” approach. Whilst there is no requirement to comply with all elements of the Corporate Governance Code for Central Government Departments, an assessment was undertaken in April 2025 against the main principles as they relate to an NHS public sector organisation in Wales.

The Trust is satisfied that it is complying with the main principles of and is conducting its business in an open and transparent manner in line with the Code. There were no reported/identified departures from the Corporate Governance Code during the 2024/25 reporting year.

Local Counter Fraud Services

The Local Counter Fraud Specialist (LCFS) is an accredited counter fraud professional who delivers both proactive work (e.g., raising fraud awareness, preventing, and deterring fraud) and reactive work to hold those who commit fraud to account (e.g., fraud investigations). The LCFS provides reports to ARAC and the ELT in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken.

Counter fraud, bribery and corruption objectives are discussed and reviewed at a strategic level within the organisation. The ARAC is accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present.

This is achieved through quarterly updates to ARAC from the LCFS; supported by an annual report on counter fraud, bribery and corruption work which complies with the NHS Counter Fraud Authority’s guidance in relation to content regarding all applicable standards for fraud, bribery, and corruption; and provides a clear update on progress against work plan objectives.

The ARAC must satisfy itself that the Trust has adequate arrangements in place for countering internal fraud and reviews the outcomes of that work, and acknowledges work completed against presented risks and an agreed work plan. The ARAC reviews and approves the internal counter fraud arrangements on an annual basis.

f) Planning Arrangements

In accordance with expectations from Welsh Government, the Trust submitted its 2024-27 IMTP by 31 March 2024 following its approval by the Board on 28 March 2024. It was approved by Welsh Government on 09 August 2024, subject to Accountability Conditions. The IMTP was developed with involvement from our stakeholders including our staff. The Trust developed its 2025-28 IMTP during 2024/25, and this was submitted to Welsh Government after approval by Board at the end of March 2025.

Within the 2024 Audit Wales Structured Assessment, in reference to corporate planning arrangements Audit Wales stated the following; *“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”.*

The Planning Team has developed comprehensive IMTP planning guidance and a project plan that guided the Trust through the development of the IMTP for 2025-28 which was approved by Board in March 2025. This addresses the Audit Wales recommendation to strengthen the Board’s oversight of the Trust’s IMTP.

The guidance has within its workstreams a clear governance and approval process, whereby there are touchpoints at Board meetings and at Board Development Days throughout the development of the plan. Additionally, there is full scrutiny at the Finance and Performance Committee and the Board as the plan comes to approval.

Further details on the Trust's IMTP and planning arrangements are set out in the Performance Report contained within the Performance Overview section of the Performance Report.

g) Disclosure Statements

The Trust confirms that in accordance with the requirements of the Governance Statement:

- Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. The Strategic Equality Plan 2024-2028 sets out the Trust's meaningful commitment to work with our people to help them recognise, promote, and celebrate equality, diversity, and inclusion. This Plan includes our approach to compliance with the Equality Act 2010, the Public Sector Equality Duty, and Socio-Economic Duty. It also outlines how the Trust will ensure the people who use ambulance services, including those with protected characteristics, have equal access and outcomes. The Plan is available on the Trust's website here: [Strategic Equality Plan 2024-2028 Welsh Ambulance Service NHS Trust](#).
- As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.
- The Trust undertakes risk assessments and has carbon delivery plans to comply with the emergency preparedness and civil contingency elements of the UKCIP (UK Climate Impacts Programme) 2009 weather projections to meet the Trust's obligations under the Climate Change Act and the Adaptation Reporting Requirements. The Trust has in place a Severe Weather Plan. In addition, the Emergency Preparedness, Resilience and Response (EPRR) team uses intelligence from the Met Office to plan ahead for adverse weather, and

weather warnings are a high priority trigger in our weekly consideration of Trust escalation levels.

The Trust works with partner agencies in our Local Resilience Fora across Wales to inform any multi-agency geographical response and the new Emergency Alert system allows for notification and warning in the event of adverse weather threats with risk to life. Planning, training, and exercising are a key aspect of the Trust's Civil Contingency responsibilities as a category one responder. Throughout 2024/25 the Trust has discussed its approach to Adaptation Planning and has included a commitment in the 2024/27 Integrated Medium-Term Plan to formalise its Adaptation Planning arrangements.

A working group has now been established across EPRR, environmental, service, clinical and capital planning areas of the Trust to complete outstanding work to risk assess using the WG adaptation planning toolkit. This will look at existing controls in place to mitigate the impacts of climate change and consider the gaps and plans that need to be put in place in addition to these existing controls as a full Adaptation Plan for the Trust.

- As set out above, the Trust had no reported serious untoward incidents during 2024/25 in relation to data security. In reporting period (01 April 2024 to 31 March 2025), three incidents were notified to the Information Commissioner's Office. Following notification, each incident was closed with no further action taken by the ICO.

Quality of Data

The quality of data generated and utilised by the Trust's core service areas is considered a collective responsibility but overseen by the Digital Directorate. Through a mature data pipeline and robust processes, the Trust maintains a strong level of data quality throughout. The Trust's Data Quality Policy outlines the importance of maintaining good data quality and clarifies the escalation process for the resolution of any discovered data quality issues.

On a monthly basis, the Trust reports key metrics of performance to Welsh Government in an Official Statistics Release. These submissions require thorough checks across all dimensions of data quality (namely: accuracy, completeness, consistency, validity, timeliness, and uniqueness), both at the call / incident level and aggregated to the higher-level views. This exercise can also involve investigation of data entries at the most granular level, whereby any issues in system, process or reporting can be identified and fixes proposed; demonstrating that data quality within the Trust takes on a full end-to-end approach. Only once the checks and balances have been signed off by senior informatics staff are the submissions supplied; given the stringent nature of this quality assurance, the Trust is named on The Official Statistics (Wales) Order 2017, which is part of the Statistics and Registration Services Act 2007.

Similarly, intelligence is offered to the Board through a variety of reports which first pass through several rounds of appropriate testing and quality assurance. Any significant changes made to data or reporting are subject to initial approval at the Insight & Data Services Changes Advisory Board and, should the findings of any impact analysis dictate a higher level of approval is required, this would be further escalated prior to implementation. With respect to Insight & Data Services and Digital Services, reports and dashboards are published to Trust systems for end users by Insight & Data Services, and are deployed in a stringent, controlled manner to maintain, wherever possible, a "single version of the truth".

In 2024, the Trust underwent a Data Quality Internal Audit and in October 2024 received the final outcome of "Reasonable Assurance". Furthermore, Insight & Data Services have now recruited two dedicated members of staff to increase capacity in the Data Quality Team and make further progress in enhancing the quality of data held and processed by the Trust.

Ministerial Directions

Ministerial Directions are published by Welsh Government as part of their health and social care publications and can be found [here](#). Of the Ministerial Directions published during the period 01 April 2024 to 31 March 2025 none were relevant to the Trust.

Welsh Health Circulars

Welsh Health Circulars provide a streamlined, transparent, and traceable method of communication between NHS Wales and NHS organisations. A number of Circulars were received during the year, and these are assigned to a lead Director who is responsible for the implementation of required actions. A log of circulars is maintained by the Trust.

h) Review of Effectiveness

As Accountable Officer for the Trust, the Chief Executive has responsibility for reviewing the effectiveness of the system of internal control. The review of the system is informed by the work of the internal auditors, and the Trust executive officers who have responsibility for the development and maintenance of the internal control framework. Additionally, comments were made by Audit Wales in their audit letter and reports, including the Structured Assessment 2024, the Follow up Review of Quality Governance Arrangements, and the Review of Cost Saving Arrangements – completed in year.

Standing Orders, Committee terms of reference and the Governance Code require that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

As set out above, each Board Committee has undergone extensive effectiveness reviews in quarter four 2024/25 resulting in changes to terms of reference to strengthen assurance and scrutiny to the Board.

The Chair's performance is evaluated annually by the Cabinet Secretary for Health and Social Care, Annual performance appraisals for the Vice Chair, Chief Executive and Non-Executive Directors are carried out by the Chair. The Chief Executive carries out appraisals of Director performance. The Remuneration Committee receives the Chief Executive's outturn position and upcoming year's objectives as well as assurance that these objectives are cascaded to the ELT.

NHS Oversight and Escalation Arrangement

Under the NHS Oversight and Escalation Arrangements, Welsh Government meet with Health Inspectorate Wales (HIW) and Audit Wales to discuss the overall assessment of the Trust.

While the tripartite evaluation involves assessment of each NHS body based on the work undertaken by the tripartite members, it is the Cabinet Secretary for Health and Social Care who determines the escalation status of NHS bodies.

At the most recent tripartite meeting the escalation status of the Trust remained unchanged at 'routine arrangements'. The Trust were advised of the outcome of this meeting on the 11 March 2025.

Health Inspectorate Wales

Health Inspectorate Wales (HIW) Report, 'Review of Patient Flow – A Journey Through the Stroke Pathway' was published in 2023/24. There were various system-wide actions generated from this report and those that related to the Trust were tracked and monitored by the QuEST Committee. The last recommendation associated with this review was completed in March 2025. There were no HIW reports received in 2024/25.

Welsh Risk Pool

During 2024 the Welsh Risk Pool (WRP) undertook an assessment of the Trust's policies, procedures, and practice as part of its oversight duties. The aim of the assessment was to gather assurance on local processes for the WRP Committee, Welsh Government and the NHS Wales Executive; and to provide recommendations to support the organisation in continuous improvement in this important area of governance. The final report was published in February 2025 and the Trust is in the process of implementing the recommendations made within the report which will be tracked and monitored by the QuEST Committee.

The Assessors were confident that the new organisational structure which has been implemented is the right approach for the Trust in respect of its patient safety and Putting Things Right processes. As there remained some outstanding actions from

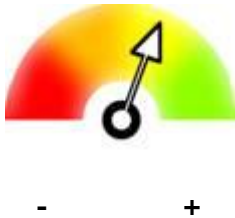
the previous assessment and inconsistency in data, the assurance rating remains as Limited Assurance. However, the Assessors were confident that as the changes being implemented by the Trust take effect, there will be sufficient evidence to increase the assurance rating.

Internal Audit

Internal Audit provides the Accountable Officer and the Board with a flow of assurance on the system of internal control. The Accountable Officer commissioned a programme of audit work which was delivered subject to agreed amendments and in accordance with Public Sector Internal Audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the ARAC and the ELT and is focussed on significant risk areas and local improvement priorities.

The overall opinion by the Head of Internal Audit on governance, risk management and control is a function of this risk-based audit programme and contributes to the picture of assurance to the Board in reviewing effectiveness and supporting our drive for continuous improvement. The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period to provide the Head of Internal Audit Annual Opinion.

The Trust develops an annual Internal Audit plan in conjunction with Internal Auditors. The plan is risk based which directs the reviews to areas where management and the ARAC considers there may be potential weaknesses. In this regard, the Trust expects to receive some limited assurance reports, and these should not detract from the overall progress the Trust continues to make. The Head of Internal Audit has concluded that: -

	The Trust Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

This conclusion is consistent with the Reasonable Assurance Head of Internal Audit Opinion reported in the Trust's 2023/24 Annual Governance Statement.

The 2024/25 reasonable assurance conclusion is derived from 20 Internal Audit reviews.

Internal Audit Assurance Conclusion	Number of Reports
Unsatisfactory Assurance	0
Limited Assurance	4
Reasonable Assurance	13
Substantial Assurance	2
Advisory	1
Total	20

For the seventh consecutive year there have been no 'Unsatisfactory Assurance' Internal Audit Reports of Trust business. Set out below are the four reports that had a conclusion of Limited Assurance that were reported to ARAC during 2024/25.

Vehicle Accident Management (Limited Assurance)

The objective of this audit was to assess the management of accidents relating to Trust vehicles, and the mitigating actions being taken to reduce the rate of occurrence.

Internal Audit recognised that the Trust's Driving at Work Policy has been reviewed, and an updated version approved by People and Culture Committee in November 2024, the cost of vehicle accidents to the Trust is low and it is currently able to better defend claims made against it.

There were six actions identified for the Trust within this report; three of which were categorised as high priority. These were in relation to the lack of recording, reporting and monitoring of vehicle accidents. The audit report was received by the Audit and Risk Assurance Committee in March 2025 and will be monitored by the People and Culture Committee throughout 2025/26.

Resourcing Policy (Limited Assurance)

The objective of this audit was 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. The outcome of a limited assurance opinion by auditors was not unexpected.

Internal Audit acknowledged that some SOPs had been produced to support the Resourcing Policy, functional SOPs were being developed to support areas such as the 111 Service and CSD. It was also noted that Weekly Unit Hour Production (UHP) reports for each function, detailing the expected staffing levels against the actual staffing levels. These reports are generated by Global Rostering System (GRS) which has a live feed, supporting decision-making regarding short notice abstraction requests. There is also regular reporting of Ambulance Abstractions and Production Indicators as part of the MIQPR, including analysis and commentary on resourcing, which is reported at Board and Committee level.

There were five actions identified for the Trust within this report; two of which were categorised as high priority. These related to the need to undertake a significant process mapping exercise to document the different approaches being applied between services and local arrangements across Wales, which result in an inconsistent application of the Resourcing Policy; and to review and report Working Time Directive breaches. The audit report was received by the ARAC in November 2024 and will be monitored by the People and Culture Committee throughout 2025/26.

Start of Shift Procedure (Limited Assurance)

The objective of this audit was to assess compliance with the Start of Shift procedure, including the preparation of vehicles and to ensure that key equipment and medicines are available. There were five actions identified for the Trust within this report; two of which were categorised as high priority.

Whilst Internal Audit recognised, anecdotally, that appropriate checks are completed by staff, there is limited evidence available to support and minimal reporting to confirm overall compliance with the expectations set out within the Trust's 'Shift Start and Finish' Standard Operating Procedure. The audit report was received by the ARAC at its meeting on 24 June 2025.

111 Wales Website (Limited Assurance)

The objective of this audit was to assess whether the 111 Wales website enables secure and effective provision of patient services. The audit report identified seven matters for the Trust to address; two of which were categorised as high priority. The audit report will be received by the ARAC at its meeting in September 2025.

Copies of all Internal Audit reports and progress reports can be obtained in the Audit Committee papers section on the Trust's website. The full Head of Internal Audit Report 2024/25 can also be found in the June 2024 ARAC papers available [here](#) and was received by the ARAC at its meeting on 24 June 2025.

External Audit – Audit Wales

The Auditor General for Wales is the Trust's statutory external auditor. Audit Wales scrutinises the Trust's financial systems and processes, performance management and key risk areas.

Reports are produced by Audit Wales in line with an ARAC approved annual programme of work and include management responses by the Trust for reports which contain recommendations. All Audit Wales reports are considered by the ARAC and, where appropriate, the relevant Committee and the Board. Their recommendations are subsequently recorded in the Trust's audit recommendations tracker, which is reported to each ARAC meeting to provide assurance on their implementation.

During 2024 the Trust was subject to three Audit Wales reviews:

- Structured Assessment 2024
- Review of Cost Saving Arrangements
- Quality Governance Follow-Up Review

Details on the outcome of these reviews have been provided below.

Structured Assessment 2024

The key annual governance report on Trust matters produced by Audit Wales is the Structured Assessment. All five recommendations identified as an outcome of the Structured Assessment for 2023 have now been completed.

The Structured Assessment for 2024 was undertaken between August and September 2024 and the final report was published and received by both the Trust Board and the ARAC in November 2024.

The key focus was 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. This Structured

Assessment was positive and indicated an improvement in the Trust's overall governance, in the operations of the Board and Committee meetings, and ensuring that there was effective oversight of key areas of risk. Key findings included:

"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".

The recommendations made in the Structured Assessment 2024 and all management responses covering some of the key areas of highlighted above were accepted and are being monitored by the ARAC. A total of three recommendations were made within the report and all have been completed. The Audit Wales Structured Assessment report for 2024 is available [here](#).

Review of Cost Saving Arrangements

Between February and May 2024, Audit Wales also undertook a review of the Trust's cost saving arrangements, examining the approaches to identifying, delivering, and monitoring sustainable cost savings opportunities. The review was positive with the key message being:

"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". This audit report is available [here](#).

Quality Governance Follow-up Review 2024

During 2021/22, the Auditor General reviewed quality governance arrangements across all Health Board and Trusts in Wales. That work focussed on operational and corporate approaches to quality governance; organisational culture and behaviours; and information flows and reporting.

A copy of the Audit Wales Quality Governance Follow-Up Review for 2024 can be found [here](#). The 2024 review sought to follow up the recommendations from the 2022 review, as well as assessing the assurance provided to the QuEst Committee that the Trust had responded appropriately to the requirements of the Duty of Quality and Duty of Candour. There is commentary regarding the output and recommendations of this audit in the 'Quality Governance' section of the Accountability Report.

i) Conclusion

The corporate governance framework at the Trust provides that the Committees are equipped – both in terms of their effective operating arrangements and membership – to receive and act on clear delegations from the Board. This allows the Board to focus on priority areas in the knowledge that the Committees are scrutinising and overseeing areas within their remit with a greater degree of detail than would be possible at the Board. Clear reporting from the Committees on an AAA basis, strengthens the confidence the Board holds in this framework.

The system-wide pressures across the NHS in Wales continue to inform the Trust's challenging operational environment and the Board Committees continue to escalate concerns to the Board regarding performance, quality of our services and avoidable harm to our patients. The Trust Board continues to prioritise how the Trust is mitigating avoidable patient harm at each of its meetings and continues to seek to influence change in the wider system. While several actions have been implemented from the Trust's perspective, they are not able to offset the impact of increasing handover delays.

The need to plan and respond to sustained system pressures, financial challenges, and Winter pressures has had a significant impact on the organisation and the wider NHS in Wales. It has required a dynamic response which has presented a number of opportunities in addition to challenges. The Board's oversight of the new performance targets for ambulance response and the wider CMT programme will be key in the 2025/26 pilot year.

The corporate governance framework will continue to improve in 2025/26, with a focus on integrated governance and assurance frameworks, support for report writers and presenters, and the further improvement of the Board and Committee SOP to provide consistency and improve quality and timeliness of papers, including minutes. The Board Visits SOP will continue to support members to triangulate assurance and promote visible leadership.

There is commitment to the WASPT – the Trust’s only Advisory Group - having a strategic focus to strengthen the relationship with our Trade Union partners, complementing and aligning its operating arrangements with the suite of Board Committees already in place.

As Accountable Officer for the Welsh Ambulance Services University NHS Trust, I confirm that the statements made in this report are correct for the year ended 31 March 2025 and up to the date of approval of the Annual Report and Accounts, that there have been no significant internal or governance issues, and I confirm that there were sound systems of internal control in place to support the delivery of the Trust’s policy aims and objectives.

Jason Killens

Chief Executive Officer

Date: 26 June 2025

j) Governance Statement Appendices

Appendix 1: Board and Committee Membership and Attendance

The Board has been constituted to comply with the National Health Service (Wales) Act 2006 and the National Health Service Trusts (Membership and Procedure) Regulations 1990 (SI 1990 No. 2024) as amended. In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Board members also fulfil a number of champion roles where they act as ambassadors for these matters.

The table below sets out the number of meetings that each Board member has attended during 2024/25 (Committee attendance figures as recorded in Committee Highlight Reports presented to Trust Board).

Name	Position	Board and Committee Record of Attendance (Actual attendance of total held meetings or total meetings available to attend, dependent on appointment dates)
Peter Curran	Non-Executive Director	Trust Board (Public): 7 of 7 Trust Board (Private): 7 of 7 Audit, Risk and Assurance Committee: 6 of 6 Charity Committee: 0 of 1 (of available meetings) Finance and Performance Committee: 6 of 6 Remuneration Committee: 3 of 4
Colin Dennis	Trust Board Chair	Trust Board (Public): 7 of 7 Trust Board (Private): 7 of 7 Remuneration Committee: 4 of 4 Quality, Patient Experience & Safety Committee: 1 of 1 (of available meetings)
Rhiannon Beaumont-Wood (appointed 11 November 2024)	Non-Executive Director	Trust Board (Public): 3 of 3 (of available meetings) Trust Board (Private): 3 of 3 (of available meetings) Audit, Risk and Assurance Committee: 0 of 1 (of available meetings) People and Culture Committee: 1 of 1 (of available meetings) Remuneration Committee: 1 of 2 (of available meetings)
Jayne Beeslee (appointed 19 August 2024)	Non-Executive Director	Trust Board (Public): 4 of 4 (of available meetings) Trust Board (Private): 4 of 5 (of available meetings) Academic Partnership Committee: 1 of 1 (of available meetings) Finance and Performance Committee: 4 of 4 (of available meetings) Remuneration Committee: 2 of 3 (of available meetings)
Kevin Davies	Non-Executive Director (until 30 September 2024)	Trust Board (Public): 2 of 4 (of available meetings) Trust Board (Closed): 3 of 4 (of available meetings) Academic Partnership Committee: 2 of 2 (of available meetings) Audit, Risk and Assurance Committee: 3 of 4 (of available meetings) Finance and Performance Committee: 2 of 3 (of available meetings) Quality, Patient Experience & Safety Committee: 2 of 2 (of available meetings) Remuneration Committee: 1 of 2 (of available meetings)

Name	Position	Board and Committee Record of Attendance (Actual attendance of total held meetings or total meetings available to attend, dependent on appointment dates)
Bethan Evans	Non-Executive Director	Trust Board (Public): 6 of 7 Trust Board (Closed): 6 of 7 Audit, Risk and Assurance Committee: 1 of 1 (of available meetings) Charity Committee: 3 of 3 (of available meetings) Finance and Performance Committee: 4 of 6 People and Culture Committee: 3 of 4 Quality, Patient Experience & Safety Committee: 3 of 4 Remuneration Committee: 1 of 4
Hayley Hutchings (appointed 11 November 2024)	Non-Executive Director	Trust Board (Public): 3 of 3 (of available meetings) Trust Board (Private): 4 of 5 (of available meetings) Academic Partnership Committee: 2 of 2 (of available meetings) People and Culture Committee: 1 of 1 (of available meetings) Remuneration Committee: 2 of 2 (of available meetings)
Ceri Jackson	Non-Executive Director	Trust Board (Public): 6 of 7 Trust Board (Closed): 5 of 7 Audit, Risk and Assurance Committee: 5 of 6 Academic Partnership Committee: 1 of 1 (of available meetings) Charity Committee: 4 of 4 People and Culture Committee: 4 of 4 Quality, Patient Experience & Safety Committee: 4 of 4 Remuneration Committee: 4 of 4
Hannah Rowan	Non-Executive Director	Trust Board (Public): 4 of 7 Trust Board (Closed): 4 of 7 Academic Partnership Committee: 4 of 4 Charity Committee: 3 of 4 People and Culture Committee: 3 of 4 Remuneration Committee: 1 of 4
Joga Singh	Non-Executive Director	Trust Board (Public): 2 of 3 (of available meetings) Trust Board (Closed): 1 of 2 (of available meetings) Audit, Risk and Assurance Committee: 2 of 3 (of available meetings) People and Culture Committee: 1 of 2 (of available meetings) Finance and Performance Committee: 2 of 2 (of available meetings) Remuneration Committee: 0 of 2 (of available meetings)
Jason Killens	Chief Executive	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 7 Remuneration Committee: 4 of 4 Audit Committee: 4 of 6 (not required attendee)
Lee Brooks	Executive Director of Operations	Trust Board (Public): 6 of 7 Trust Board (Closed): 7 of 7 Charity Committee: 3 of 4 Finance and Performance Committee: 5 of 6 People and Culture Committee: 3 of 4 Quality, Patient Experience & Safety Committee: 2 of 4
Carl Kneeshaw (from 01 November 2024)	Director of People	Trust Board (Public): 3 of 3 (of available meetings) Trust Board (Closed): 3 of 3 (of available meetings) Audit, Risk and Assurance Committee: 2 of 2 (of available meetings) Academic Partnership Committee: 2 of 2 (of available meetings)



Name	Position	Board and Committee Record of Attendance (Actual attendance of total held meetings or total meetings available to attend, dependent on appointment dates)
		Finance and Performance Committee: 3 of 3 (of available meetings) People and Culture Committee: 2 of 2 (of available meetings) Remuneration Committee: 2 of 2 (of available meetings)
Angela Lewis (Change in portfolio from 01 November 2024)	Director of Culture Change	Trust Board (Public): 7 of 8 Trust Board (Closed): 7 of 7 Audit, Risk and Assurance Committee: 3 of 4 (of available meetings) Academic Partnership Committee: 2 of 2 (of available meetings) Finance and Performance Committee: 2 of 3 (of available meetings) People and Culture Committee: 4 of 4 Remuneration Committee: 1 of 2 (of available meetings)
Estelle Hitchon	Director of Partnerships and Engagement	Trust Board (Public): 6 of 7 Trust Board (Closed): 6 of 7 Academic Partnership Committee: 4 of 4 Charity Committee: 4 of 4 People and Culture Committee: 4 of 4
Rachel Marsh	Executive Director of Strategy, Planning and Performance	Trust Board (Public): 6 of 7 Trust Board (Closed): 7 of 7 Finance and Performance Committee: 2 of 6 Quality, Patient Experience & Safety Committee: 2 of 4
Trish Mills	Director of Corporate Governance / Board Secretary	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 7 Academic Partnership Committee: 3 of 4 Audit, Risk and Assurance Committee: 6 of 6 Charity Committee: 3 of 4 Finance and Performance Committee: 5 of 6 People and Culture Committee: 3 of 4 Quality, Patient Experience & Safety Committee: 3 of 4 Remuneration Committee: 4 of 4
Jonny Sammut	Director of Digital Services	Trust Board (Public): 6 of 7 Trust Board (Private): 6 of 7 Academic Partnership Committee: 1 of 4 Finance and Performance Committee: 6 of 6 Quality, Patient Experience & Safety Committee: 4 of 4
Andy Swinburn	Executive Director of Paramedicine	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 7 Academic Partnership Committee: 4 of 4 Charity Committee: 4 of 4 People and Culture Committee: 4 of 4 Quality, Patient Experience & Safety Committee: 4 of 4
Chris Turley	Executive Director Finance and Corporate Resources	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 7 Audit, Risk and Assurance Committee: 5 of 6 Charity Committee: 4 of 4 Finance and Performance Committee: 6 of 6 People and Culture Committee: 4 of 4

Name	Position	Board and Committee Record of Attendance (Actual attendance of total held meetings or total meetings available to attend, dependent on appointment dates)
Liam Williams	Executive Director of Quality and Nursing	Trust Board (Public): 6 of 7 Trust Board (Closed): 6 of 7 Audit, Risk and Assurance Committee: 2 of 6 Finance and Performance Committee: 3 of 6 People and Culture Committee: 3 of 4 Quality, Patient Experience & Safety Committee: 4 of 4

Appendix 2: Board and Committee Meeting Dates

The following table sets out the dates of the Trust Board and Committee meetings held in 2024/25. All Trust Board and Board Committee meetings in 2024/25 achieved quorum.

Meeting Title [meetings held]	Meeting Dates 2024/25
Trust Board (Public) [7]	30 May 2024; 12 July 2024 (extraordinary); 25 July 2024; 26 September 2024; 29 November 2024; 30 January 2025; 27 March 2025
Trust Board (Closed) [7]	30 May 2024; 25 July 2024; 09 September 2024 (extraordinary); 26 September 2024; 29 November 2024; 30 January 2025; 27 March 2025
Corporate Trustee [3]	30 May 2024; 29 November 2024; 30 January 2025
Academic Partnership Committee [4]	23 April 2024; 19 July 2024; 18 November 2024; 23 January 2025
Audit, Risk and Assurance Committee [6]	20 April 2024; 07 June 2024; 10 July 2024; 12 September 2024; 21 November 2024; 06 March 2025
Charity Committee [4]	04 April 2024; 22 August 2024; 08 October 2024; 14 January 2025
Finance and Performance Committee [6]	14 May 2024; 16 July 2024; 17 September 2024; 19 November 2024; 16 January 2025; 18 March 2025
People and Culture Committee [4]	09 May 2024; 30 August 2024; 14 November 2024; 18 February 2025
Quality, Patient Experience and Safety Committee [4]	07 May 2024; 13 August 2024; 05 November 2024; 04 February 2025
Remuneration Committee [4]	21 May 2024; 29 August 2024; 05 December 2024; 13 March 2025

2.2 Modern Slavery Act 2015 – Transparency in Supply Chains

The Trust has signed up to and is fully committed to the Welsh Government Code of Practice Ethical Employment in Supply Chains. This has been established by the Welsh Government to support the development of more ethical supply chains to deliver contracts for the Welsh public sector and third sector organisations in receipt of public funds. The procurement function is a key area for ethical employment in supply chains. This is run by NHS Wales Shared Services Partnership. More information can be found on the work done on the Health Board's behalf by NWSSP on the Shared Services Partnership website.

2.3 Remuneration and Staff Report

The Remuneration and Staff Report contains information about senior managers' remuneration. It will detail salaries and other payments, the Trust's policy on senior managers remuneration and whether there were any exit payments or other significant awards to current or former senior managers.

The definition of senior managers as prescribed by the 2024/25 Manual for Accounts Chapter three is: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments'.

For the Trust, the senior managers are considered to be the Board's members, i.e., the Executive and Non-Executive Directors including the Chair and Chief Executive; and five further (non-voting) Directors.

In addition to presenting data on senior managers' remuneration, the Remuneration and Staff Report sets out the membership of the Trust's Remuneration Committee, and staff information with regards to numbers, composition, and sickness absence, together with expenditure on consultancy and off payroll expenditure.

Membership of the Remuneration Committee

Details of the members of the Remuneration Committee are shown in the Governance Statement, within the summary of Board Committees section. The changes to the membership of the Committee in-year reflected the changes to the Non-Executive Directors on the Board.

Statement of Policy on the Remuneration of Senior Managers

All senior managers' pay, and terms and conditions of service are determined by the Remuneration Committee within the framework set by the Welsh Government. Performance of senior managers is assessed against personal objectives and the overall performance of the Trust. The process sets objectives for the year and assesses individual performance against the objectives. The Trust does not make performance or other related bonus payments.

In keeping with the Welsh Government Circulars on pay for senior managers in NHS Wales for 2024/25, a 5% consolidated pay uplift was applied to all pay scales for individuals holding executive and senior posts, effective from 01 April 2024. This pay uplift was agreed in September 2024 and applied retrospectively.

This uplift has been applied to all pay scales, including those senior staff of the Trust who are on individually negotiated spot rates in accordance with the pay Circulars. This uplift is not applicable to Non-Executive Directors.

Policy on Duration of Contracts and Notice Periods

The Trust utilises permanent and fixed term contracts of employment as well as secondment opportunities. For other staff, the contractual notice staff are required to give to the Trust and which staff are entitled to receive, is as follows: Bands one-six is four weeks; Band seven is eight weeks; Bands eight and nine is 12 weeks.

The notice provisions for Pay Bands one-seven outlined above are the normal notice periods of notice. However, these provisions do not override the statutory notice requirements the Trust is required to provide its staff. According to length of service, staff may be entitled to a greater period of notice and receive one week's notice for each completed year of service up to and including a maximum of 12 weeks' notice after 12 years of continuous employment.

This refers to the notice periods staff must give; however, this does not preclude individuals requesting an earlier release from their post. This does not affect the right of either party to terminate the contract without notice by reason of the conduct of the other party. The Trust may, depending on circumstances, pay salary in lieu of notice.

Senior Manager Contracts and Awards

Details of senior manager contracts are shown in the tables below. There was no payment for early termination to senior managers' contracts during 2024/25.

Remuneration Relationship

Details of the Trust's remuneration relationship is set out in Note 10.6 of the 2024/25 Annual Accounts.

Senior Managers in Post in 2024/25

Name	Position Title	Assignment Category	Start Date in Position	Fixed Term End Date
Rhiannon Beaumont-Wood	Non-Executive Director	Fixed Term	11 November 2024	10 November 2028
Jayne Beeslee	Non-Executive Director	Fixed-Term	19 August 2024	18 August 2028
Peter Curran	Non-Executive Director	Fixed Term	01 February 2024	31 January 2028
Colin Dennis	Chair	Fixed Term	01 October 2022	30 September 2026
Bethan Evans	Non-Executive Director	Fixed Term	06 December 2019	5 December 2026
Hayley Hutchings	Non-Executive Director	Fixed Term	11 November 2024	10 November 2028
Ceri Jackson	Vice-Chair	Fixed Term	01 July 2024	30 June 2028
Hannah Rowan	Non-Executive Director	Fixed Term	01 April 2022	31 March 2026
Jason Killens	Chief Executive Officer	Permanent	Prior to 01 April 2021	Not Applicable
Christopher Turley	Executive Director of Finance and Corporate Resources	Permanent	Prior to 01 April 2021	Not Applicable
Angela Lewis	Director of Culture Change	Fixed Term	12 September 2022	31 October 2026

Name	Position Title	Assignment Category	Start Date in Position	Fixed Term End Date
Liam Williams	Executive Director of Quality and Nursing	Permanent	01 August 2022	Not Applicable
Lee Brooks	Executive Director of Operations	Permanent	Prior to 01 April 2021	Not Applicable
Estelle Hitchon	Director of Partnerships and Engagement	Permanent	Prior to 01 April 2021	Not Applicable
Rachel Marsh	Executive Director of Strategy, Planning and Performance	Permanent	Prior to 01 April 2021	Not Applicable
Patricia Mills	Director of Corporate Governance/Board Secretary	Permanent	02 August 2021	Not Applicable
Jonathan Sammut	Director of Digital	Permanent	27 September 2023	Not Applicable
Andrew Swinburn	Executive Director of Paramedicine	Permanent	01 December 2021	Not Applicable
Carl Kneeshaw	Director of People	Permanent	01 November 2024	Not Applicable

Further details of the contract arrangements of the Trust's senior managers in 2024/25 can be found in the Remuneration Table (and Notes) set out later in this Remuneration and Staff Report. Where there have been changes to the Director positions, changes to terms or resignations in-year, further detail can be found in the Directors' Report (at the beginning of the Accountability Report).

Senior Managers filling posts on an Interim Basis during 2024/25

There were none during this financial year.

Senior Managers who left the Trust during 2024/25

Name	Position Title	Assignment Category	Start Date in Position	Leaving Date
Professor Kevin Davies	Non-Executive Director	Fixed Term	19 December 2014	30 September 2024
Anoop Joga Singh	Non-Executive Director	Fixed Term	09 December 2019	31 August 2024

Hutton Report Information (audited information)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director /employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

				2024-25	2024-25	2024-25		2023-24	2023-24	2023-24
				Chief Executive	Employee	Ratio		Chief Executive	Employee	Ratio
Total pay and benefits	25th percentile pay ratio			187,500	30,420	6.16:1		172,500	28,906	5.97:1
	Median pay			187,500	38,999	4.81:1		172,500	36,067	4.78:1
	75th percentile pay ratio			187,500	53,416	3.51:1		172,500	48,629	3.55:1
Salary component of total pay and benefits										
	25th percentile pay ratio			187,500	26,060			177,500	24,701	
	Median pay			187,500	30,420			177,500	28,010	
	75th percentile pay ratio			187,500	45,637			177,500	43,257	
				Highest Paid Director	Employee	Ratio		Highest Paid Director	Employee	Ratio
Total pay and benefits	25th percentile pay ratio			187,500	30,420	6.16:1		172,500	28,906	5.97:1
	Median pay			187,500	38,999	4.81:1		172,500	36,067	4.78:1
	75th percentile pay ratio			187,500	53,416	3.51:1		172,500	48,629	3.55:1
Salary component of total pay and benefits										
	25th percentile pay ratio			187,500	26,060			177,500	24,701	
	Median pay			187,500	30,420			177,500	28,010	
	75th percentile pay ratio			187,500	45,637			177,500	43,257	

In 2024/25, 0 (2023-24, 0) employees received remuneration in excess of the highest-paid director. Remuneration for all staff ranged from £23,970 to £187,500 (2023-24, £22,720 to £177,500). The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

*In terms of these disclosures, the Chief Executive is also the highest paid director.

Financial Year Summary (audited information)

In keeping with the Welsh Government circulars on pay, included in the calculations for 2024/25 are the 5.5% pay increase for employees covered by Agenda for Change (AfC) and the 5.0% pay increase for employees covered by Executive and Senior Posts (ESP).

Prior year figures have not been adjusted to take account of the revised Manual for Accounts guidance, this has been applied for 2024/25 only, therefore salary sacrifice schemes are still currently deducted from the 2023/24 figures included under total pay and benefits.

10.6.2 Percentage Changes		2023-24 to 2024-25 %	2022-23 to 2023-24 %
% Change from previous financial year in respect of Chief Executive			
	Salary and allowances	8.7	3.0
	Performance pay and bonuses	0	0
% Change from previous financial year in respect of highest paid director			
	Salary and allowances	8.7	3.0
	Performance pay and bonuses	0	0
Average % Change from previous financial year in respect of employees taken as a whole			
	Salary and allowances	7.8	5.0
	Performance pay and bonuses	0	0

Prior year figures have not been adjusted to take account of the revised Manual for Accounts guidance; this has been applied for 2024-25 only. The 3.0% reported in 2023/24 is in relation to the pay award received in 2023/24, based on the mid-point of the band.

The 8.7% reported in 2024/25 is in relation to the pay award received in 2024/25 based on the mid-point of the band, and the exclusion of salary sacrifice schemes as per the new guidance.

If the prior year had been adjusted, the % change from previous financial year in respect for Chief Executive and the highest paid director would be 5.6%, based on the mid-point of the band. The 5.0% in 2023/24 in terms of the average pay per FTE was related to the pay award received and accrued for during 2023/24. The 7.8% reported in 2024/25 relates to the agreed pay increases across the organisation, with salary sacrifice schemes excluded.

If the prior year had been adjusted, the average % change from previous financial year in respect of employees taken as a whole would be 6.1%.

Salary and Pensions Entitlements of Senior Managers

a) Remuneration (audited information)

Name and Title	2024-25				2023-24			
	Salary £000 (bands of £5000)	Benefits in Kind £ Rounded to the nearest £100	Pension benefits £000 Rounded to the nearest £1000 (Note 23)	Total £000 (bands of £5000)	Salary £000 (bands of £5000) (Note 22)	Benefits in Kind £ Rounded to the nearest £100	Pension benefits £000 Rounded to the nearest £1000	Total £000 (bands of £5000)
Colin Dennis (Chair)	40-45	2,000		45-50	40-45			40-45
Kevin Davies (Non Executive Director / Vice Chair) (Note 1)	0-5	100		0-5	15-20			15-20
Paul Holland (Non Executive Director) (Note 2)					5-10			5-10
Martin Turner (Non Executive Director) (Note 3)					5-10			5-10
Anoop Joga Singh (Non Executive Director) (Note 4)	0-5	-		0-5	5-10			5-10
Bethan Evans (Non Executive Director)	5-10	100		5-10	5-10			5-10
Ceri Jackson (Non Executive Director / Vice Chair) (Note 5)	20-25	1,100		20-25	10-15			10-15
Hannah Rowan (Non Executive Director)	5-10	-		5-10	5-10			5-10
Peter Curran (Non Executive Director) (Note 6)	5-10	100		5-10	0-5			0-5
Jayne Beeslee (Non Executive Director) (Note 7)	5-10	200		5-10				
Rhiannon Beaumont-Wood (Non Executive Director) (Note 8)	0-5	100		0-5				
Hayley Hutchings (Non Executive Director) (Note 9)	0-5	200		0-5				
Jason Killens (Chief Executive) (Note 10)	175-180	1,400		175-180	170-175	-	-	170-175
Christopher Turley (Executive Director of Finance & Corporate Resources) (Note 11)	130-135	300	29	160-165	120-125	-	-	120-125
Dr Brendan Lloyd (Executive Director of Medical and Clinical Services) (Note 12)					60-65	-		60-65
Angela Lewis (Director of Culture Change) (Note 13)	95-100	-	25	120-125	110-115	-	27	140-145
Liam Williams (Executive Director of Quality and Nursing)	130-135	-	12	140-145	120-125	-	-	120-125
Estelle Hitchon (Director of Partnerships & Engagement) (Note 14)	110-115	-	42	155-160	105-110	-		105-110
Rachel Marsh (Executive Director of Strategy, Planning & Performance) (Note 15)	115-120	700		115-120	105-110	-	-	105-110
Lee Brooks (Executive Director of Operations) (Note 16)	120-125	1,500	33	155-160	110-115	-	30	140-145
Dr Leanne Smith (Interim Director of Digital Services) (Note 17)					60-65	-	13	75-80
Jonathan Sammut (Director of Digital Services) (Note 18)	110-115	3,700		110-115	55-60	-	2	60-65
Andrew Swinburn (Executive Director of Paramedicine) (Note 19)	120-125	1,700	23	145-150	110-115	-	-	110-115
Carl Kneeshaw (Director of People) (Note 20)	45-50	-	11	60-65				
Patricia Mills (Director of Corporate Governance / Board Secretary) (Note 21)	105-110	-	28	130-135	100-105	-	26	125-130

Note 1 - Kevin Davies was Vice Chair until 30th November 2023, and Non Executive Director from 1st December 2023 until leaving the Trust on 30th September 2024

Note 2 - Paul Holland left the Trust on 31st March 2024

Note 3 - Martin Turner left the Trust on 31st January 2024

Note 4 - Anoop Joga Singh left the Trust on 31st August 2024

Note 5 - Ceri Jackson was Non Executive Director until 30th November 2023 and Interim Vice Chair from 1st December 2023. Ceri was appointed as Vice Chair from 1st July 2024

Note 6 - Peter Curran joined the Trust on 1st February 2024

Note 7 - Jayne Beeslee joined the Trust on 19th August 2024. Salary full year equivalent is 5-10 (bands of £5000)

Note 8 - Rhiannon Beaumont-Wood joined the Trust on 11th November 2024. Salary full year equivalent is 5-10 (bands of £5000)

Note 9 - Hayley Hutchings joined the Trust on 11th November 2024. Salary full year equivalent is 5-10 (bands of £5000)

Note 10 - Jason Killens' salary before a salary sacrifice of £9,501 was 185-190 (bands of £5000). 2023-24 salary before a salary sacrifice of £5,742 was 175-180 (bands of £5000)

Note 11 - Christopher Turley's salary before a salary sacrifice of £2,078 was 130-135 (bands of £5000) including £2,518 in terms of annual leave sold. 2023-24 salary before a salary sacrifice of £5,306 was 125-130 (bands of £5000) including £2,391 in terms of annual leave sold

Note 12 - Brendan Lloyd retired on 31st December 2023. Salary is based on 0.51 WTE (19 hours). Salary full year equivalent is 80-85 (bands of £5000)

Note 13 - Angela Lewis' job title changed from Director of Workforce & Organisational Development to Director of People & Culture from 20th April 2023. Angela was appointed Director of Culture Change from 1st November 2024 on a 0.6 WTE basis (22.5 hours), salary full year equivalent is 115-120 (bands of £5000)

Note 14 - Estelle Hitchon's salary includes £2,162 in terms of annual leave sold. 2023-24 salary included £2,054 in terms of annual leave sold

Note 15 - Rachel Marsh's salary before a salary sacrifice of £5,006 was 120-125 (bands of £5000) including £2,281 in terms of 2024-25 annual leave sold and £1,550 in terms of 2023-24 annual leave sold. 2023-24 salary before a salary sacrifice of £5,006 was 110-115 (bands of £5000)

Note 16 - Lee Brooks' salary before a salary sacrifice of £10,415 was 130-135 (bands of £5000). 2023-24 salary before a salary sacrifice of £10,415 was 125-130 (bands of £5000)

Note 17 - Dr Leanne Smith was appointed Interim Director of Digital Services from 1st August 2022 until 11th October 2023. Salary full year equivalent is 115-120 (bands of £5000)

Note 18 - Jonathan Sammut was appointed Director of Digital Services from 27th September 2023. Salary before a salary sacrifice of £14,689 was 125-130 (bands of £5000). 2023-24 salary before a salary sacrifice of £2,448 was 60-65 (bands of £5000)

Note 19 - Andrew Swinburn salary before a salary sacrifice of £11,555 was 135-140 (bands of £5000) including £2,518 in terms of 2024-25 annual leave sold and £2,430 in terms of 2023-24 annual leave sold. 2023-24 salary before a salary sacrifice of £9,629 was 120-125 (bands of £5000)

Note 20 - Carl Kneeshaw joined the Trust on 1st November 2024, with pension contributions from 4th November 2024 due to an overlap in employments. Salary full year equivalent is 115-120 (bands of £5000)

Note 21 - Patricia Mills' job title was changed from Board Secretary to Director of Corporate Governance/Board Secretary from 8th March 2024

Note 22 - The 2023-24 salary column includes an increase of 5% on top of the pay scales for employees covered by executive and senior pay terms and conditions of service

Note 23 - In line with Disclosure of Senior Managers' Remuneration (Greenbury) 2025 guidance, pension benefits are only included where the calculation results in a positive figure

Note 24 - Payments to past directors Claire Vaughan and Andrew Haywood were made for £86.79 and £474.02 respectively relating to 2022/23 back pay which was not disclosed previously in a directors' remuneration report, in accordance with the Manual for Accounts

Note 25 - Benefit in kind includes home to work travel and business miles for the Non Executive Directors, and company car and fuel for the Directors

Salary and Pensions Entitlements of Senior Managers

b) Pension Benefits (audited information)

Name and title	Accrued pension at pension age as at 31/3/25 and related lump sum (bands of £5,000) £'000	Real increase in pension and related lump sum at pension age (bands of £2,500) £'000	Cash Equivalent Transfer Value at 31 March £'000	Cash Equivalent Transfer Value at 31 March £'000	Real increase in Cash Equivalent Transfer £'000
Jason Killens (Chief Executive)	60-65 plus lump sum of 150-155	0-2.5 plus lump sum of 0	1,312	1,222	-
Christopher Turley (Executive Director of Finance & Corporate Resources)	60-65 plus lump sum of 155-160	0-2.5 plus lump sum of 0	1,382	1,245	37
Angela Lewis (Director of Culture Change)	5-10 plus lump sum of 0-5	0-2.5 plus lump sum of 0	113	76	19
Liam Williams (Executive Director of Quality and Nursing)	40-45 plus lump sum of 105-110	0-2.5 plus lump sum of 0	953	865	14
Estelle Hitchon (Director of Partnerships & Engagement)	35-40 plus lump sum of 100-105	2.5-5 plus lump sum of 0-2.5	867	755	47
Rachel Marsh (Executive Director of Strategy, Planning & Performance)	55-60 plus lump sum of 65-70	0-2.5 plus lump sum of 0	1,044	957	9
Lee Brooks (Executive Director of Operations)	45-50	0-2.5	639	562	24
Jonathan Sammut (Director of Digital Services) *	-	-	-	56	-
Andrew Swinburn (Executive Director of Paramedicine)	50-55 plus lump sum of 130-135	0-2.5 plus lump sum of 0	1,166	1,052	29
Carl Kneeshaw (Director of People) **	0-5	0-2.5	53	24	5
Patricia Mills (Director of Corporate Governance / Board Secretary)	5-10	0-2.5	155	112	22
* Jonathan Sammut chose not to be covered by the NHS pension arrangements from 1 February 2024					
** Carl Kneeshaw paid pension contributions from 4th November 2024 due to an overlap in pensionable employments					

Staff Numbers (audited information)

An analysis of staff numbers by category during 2024/25 are set out below. The figures relate to the average number of employees under contract of service in each month of the financial year, divided by 12 (and rounded to nearest Whole Time Equivalent [WTE]). These figures have been calculated to include inward secondments and agency staff and to reconcile with the financial accounts.

Category	2024/25	2023/24	2022/23
Additional Clinical Services	1,974	2,070	2,078
Professional, Scientific & Technical Staff	3	3	4
Administrative, Clerical and Board Members	690	634	618
Allied Health Professionals	1,162	1,103	1,092
Estates & Ancillary	65	58	64
Medical & Dental	1	1	1
Nursing and Midwifery	196	192	196
Total	4,091	4,061	4,053

Staff Composition

An analysis of the number of persons of each sex who are senior managers of the Trust (i.e., Non-Executive Directors, Executive Directors, Directors, Board Secretary) as at 31 March 2025, are set out below (excludes secondees out of the Trust). This compares to a Trust wide staff composition of 51% female, 49% male.

Gender	Headcount	%
Female	10	53
Male	9	47
Total	19	100

Sickness Absence Data

	2024/25	2023/24	2022/23
Days lost (long term)	85,949.54	93,684.07	88,732.85
Days lost (short term)	30,280.98	32,961.72	47,226.89
Total days lost	116,230.52	126,645.79	135,959.74
Total staff years	338.88	338.43	335.66
Average working days lost	17.86	19.43	21.09
Total staff employed in period (headcount)	4,381	4,354	4,315
Total staff employed in period with no absence (headcount)	1262	1,025	917
Percentage staff with no sick leave	28.65%	24.93%	21.09%

Note 1: The percentage and total number of staff without absence in the year has been sourced from the standard Electronic Staff Record (ESR) Business Intelligence (BI) report. With regard to the reporting in relation to the percentage of staff with 'no sickness', the standard BI report excludes new entrants and also bank assignments. Therefore, the number of staff who have had a whole year with no sickness absence is being divided into a smaller number than the total headcount at the end of the year.

The close management of sickness absence in accordance with policy and procedures continues and Trust is not out of kilter with the wider UK ambulance sector.

There has been a reduction in absence from 7.67% in March 2024 to 7.35% in March 2025 and the organisation continues to work to reduce this figure noting the levels of reduction become increasingly challenging as the figure reduces. Actions include:

- Further embedding of compassionate practices approaches to reduce employee harm from organisational processes.
- Using opportunities such as temporary or permanent flexible working arrangements to support colleagues to remain at work and sustain their employment.
- Reporting to the ELT, PCC and Trust Board including deep dives on specific issues and areas for oversight and governance.
- The delivery of innovative projects and cultural improvement work to benefit employee experience which, in turn, helps in reducing sickness absence.
- Work in partnership with Trade Union (TU) colleagues on areas impacting attendance such as handover delays and staff being able to take Time off in Lieu when they need and want to.
- Dedicated and effective change management support and approaches for transformation and restructuring projects.
- Regular and proactive support from the People Services Team including case reviews with senior managers for visibility and accountability.

Staff Policies Applied During the Year

The Trust has a comprehensive policy framework which outlines the development, review, and approval of its employment policies and procedures in partnership. Throughout 2024/25 the Trust has continued to develop, review, and update several policies in partnership with TU colleagues and through staff consultations; aiming to streamline and simplify the Trust's processes further.

All approved employment policies and procedures are equality impact assessed against the nine protected characteristics, with Welsh Language considered additionally to ensure they do not discriminate or disadvantage any individuals. These policies are designed to ensure that equality and diversity considerations are fully integrated into the Trust's recruitment, selection, and employment practices, reflecting the organisational core values and behaviours.

The Trust offers a wide range of employment policies covering areas such as recruitment and selection, training and development, flexible working, health and safety, wellbeing, and infection control. These policies are supported by the Trust's People and Culture Plan and Strategic Equality Plan. Staff can access all employment policies via the Trust's Intranet.

Other Employee/Staff Matters

Significant progress has been made over the past year to achieve the Trust's strategic equality objectives. The activity across the Trust in furtherance of these objectives is as follows: -

Sexual Safety, Misogyny and Violence Against Women and Girls

The Trust is committed to creating safe work environments and eliminating sexual harassment and unwanted behaviours in the workplace. We have developed a multi-level training plan to raise awareness and address sexual harassment. This comprehensive approach aims to ensure a safe and respectful workplace for all employees and will help to create safer and more inclusive working environments.

Allyship and Active Bystander Training

The Trust continues to implement its Allyship and Active Bystander Training to staff and volunteers across the Trust. This training aims to enhance awareness and understanding of the challenges faced by minority and protected groups, as well as vulnerable and disadvantaged individuals. The training promotes practical approaches to bystander intervention, encouraging staff to actively eliminate discriminatory behaviours and foster equity. The training was recognised as an exemplary programme of work in 2024 when the Trust has won a Healthcare People Management Association Cymru Award.

People Networks and our Volunteers

Our People Networks continue to progress with the following networks actively operating across the Trust:

- *Women's Network*
- *BEAM Network*
- *LGBTQ+ Network*
- *Carer Peer Support Network*
- *Purple Space Network*
- *Culture Champions*
- *WAST Voices*
- *Change Community*
- *Welsh Language Network*

We have reached out to our volunteers and extended an invitation for them to join our people networks. Our volunteers are much more diverse than our current workforce and deserve equal access to our support networks. We also recognise the value and lived experience of our volunteers who can help us drive forward our people network initiatives.

Support for Carers

The Trust was awarded Carer Confident Level 1 and continues to provide support for our workforce who provide unpaid care for others. A promotional campaign about the Carers Leave Act was also implemented to provide further support for carers and line managers. As a result of publicity around the Carer Confident Award, we have seen an increase in the numbers of colleagues wishing to join our Carer's Network.

Anti-Racist Wales Action Plan Update

Following the launch of Welsh Government's updated Anti-racist Wales Action Plan (ARWAP) in November 2024, the Trust has reviewed the progress made to date and developed a new local action plan. This year, we have made progress in the following areas:

Inclusive Recruitment Initiative within the Digital Team

Three unconscious bias training sessions were delivered to six recruiting managers, and two workshops were hosted for ethnically diverse applicants. The Equity, Diversity and Inclusion Team supported the Team to reach out to ethnically diverse communities to target their recruitment activity. Early analysis of the recruitment activity undertaken to date has shown a noticeable increase in applicants from ethnically diverse candidates and successful appointments of Black, Asian and Ethnic Minority applicants. This work was promoted at the Mastering Diversity Conference Wales, where the Trust led the 'Digital Zone' which focussed on inclusive recruitment within the digital sector, with an emphasis on women and intersectionality.

Maternity Skin Tone Initiative

Our Midwife Local Safety Champion has arranged for black skin tone simulation mannequins to be procured to enhance training for childbirth. This includes a birth simulator mannequin, neonatal mannequins, adult CardioPR mannequins, a suture kit and intravenous arm. Our Public Health Registrar has analysed population data to identify areas with high numbers of ethnic minority emergency care births and as a result, these mannequins will be added to our training suites in Swansea, Cardiff and Newport. The training resources will also be loaned out to other areas to ensure that all staff have an opportunity to train with black skin tone simulation mannequins.

Ramadan and Iftar Event

Over the past year, the Trust has been building relationships with our Muslim communities. In addition to visiting local mosques and community groups, The Trust's newly established BEAM Network facilitated the Trust's attendance at the Halal Expo event in Cardiff in February. This event saw approximately 3000 visitors throughout the day where staff worked with children to practice CardioPR skills, listened to service user experiences, and promoted volunteering and recruitment opportunities within the Trust. In March, the network hosted the Trust's first Iftar event which was well attended with representation from our Trust Board, including Non-Executive Directors, and provided an opportunity to learn about Ramadan and the breaking of the fast. Staff and volunteers were invited to share traditional food with our Muslim colleagues and watch prayers. The Secretary General for the Muslim Council of Wales also attended and delivered a talk about Ramadan. Attendees were appreciative of the event and commented on how much they learned about Muslim culture which will help us create allyship and a better understand the needs of our Muslim colleagues and service users.

Support for LGBTQ+ Communities

Following feedback from our LGBTQ+ communities, this year, the Trust increased its presence at Pride events across Wales. Staff and volunteers attended Pride events in South, North, and West Wales where network members were able to come together with our local communities to learn about some of the specific challenges that they are facing. The Chair of our LGBTQ+ Staff Network has used this feedback and engagement to help inform the development of the Ambulance Association of Chief Executives LGBTQ+ Action Plan for 2025 which focuses on developing support for LGBTQ+ Network Chairs, updating a Continual Professional Development resource around Providing Good Care for People Living with HIV, and a developing new LGBTQ+ mental health resource.

Expenditure on Consultancy

Expenditure during 2024/25 in respect of consultancy costs was £583,645.36 (in 2023/24 it was £496,519.09) across the following areas:

154,158.00	Programme and Project Management
96,999.80	Organisation and Change Management
57,351.81	Human Resource, training and education
-	IT/IS
71,198.30	Property and Construction
-	Marketing and Communication
157,868.90	Strategy
32,904.80	Finance
13,163.75	Technical
-	Legal Services

583,645.36

Expenditure on Temporary Staff

Narrative Comparison between 2024/25 and 2023/24

Expenditure during 2024/25 in respect of temporary staff costs was £1.407m (2023/24 £1.104m). The increase of £0.303k is due to digital agency staff in post on a non-recurrent basis to assist in the delivery of agreed IMTP deliverables, this is largely due to the difficulties in recruiting to such a specialist area.

Off-Payroll Engagements

The Trust has a nil return in 2024/25 for off-payroll engagements. This is consistent with that reported in 2023/24.

Exit Packages (audited information)

The Trust has a cost of £164,365 in 2024/ 25 for five staff exit packages. This compares to a return of £53,678 in 2023/24. Exit packages are described in Note 10.5 within the financial statements.

2.4 Senedd Cymru/Welsh Parliamentary Accountability and Audit Report

The Senedd Cymru/Welsh Parliamentary Accountability and Audit Report provides information on such matters as regularity of expenditure, fees and charges, and the audit certificate and report.

Regularity of Expenditure

The Trust is required to ensure regularity of its income and expenditure. Sufficient evidence of the assurance of this has been provided as part of the audit of the accounts process and the audit certificate for the accounts concludes that in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by Welsh Parliament and that the financial transactions recorded in the financial statements conform to the authorities which govern them. The Trust confirms its expenditure for the year is regular.

Fees and Charges

The Trust is required by Welsh Government to ensure that the full cost of providing commercial services is passed on in its fees and charges and confirms that proper controls were in place in 2024/25 over how, when and at what level charges were levied. The Trust confirms its fees and charges are in accordance with Welsh Government requirements.

Material Remote Contingent Liabilities

The Trust has no material remote contingent liabilities within its 2024/25 accounts. This is consistent to that reported in 2023/24.

Audit Certificate and Report

The certificate and report of the Auditor General to the Welsh Parliament is attached on the following pages.

The Certificate and independent auditor's report of the Auditor General for Wales to the Senedd

Opinion on financial statements

I certify that I have audited the financial statements of Welsh Ambulance Services University NHS Trust for the year ended 31 March 2025 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Cash Flow Statement and the Statement of Changes in Taxpayers' Equity and related notes, including a summary of material accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- give a true and fair view of the state of affairs of Welsh Ambulance Services University NHS Trust as at 31 March 2025 and of its surplus/deficit for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the trust in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for Welsh Ambulance Services University NHS Trust adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers. In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers' directions; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability Report. I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- I have not received all the information and explanations I require for my audit
- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records.
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view.
- ensuring that the annual report and financial statements as a whole are fair, balanced, and understandable.
- ensuring the regularity of financial transactions.
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; and

- assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors and Chief Executive anticipate that the services provided by the Trust will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to Welsh Ambulance Services University NHS Trust's policies and procedures concerned with:
- identifying, evaluating, and complying with laws and regulations and whether they were aware of any instances of non-compliance.
- detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected, or alleged fraud; and



- the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in management override and expenditure recognition.
- Obtaining an understanding of Welsh Ambulance Services University NHS Trust's framework of authority as well as other legal and regulatory frameworks that the Welsh Ambulance Services University NHS Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of Welsh Ambulance Services University NHS Trust; and
- Obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above.
- enquiring of management, the Audit, Risk and Assurance Committee and legal advisors about actual and potential litigation and claims.
- reading minutes of meetings of those charged with governance and the Board.
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of Welsh Ambulance Services University NHS Trust's controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report

I have no observations to make on these financial statements.

Adrian Crompton	1 Capital Quarter
Auditor General for Wales	Tyndall Street
XXX	Cardiff
	CF10 4BZ

PART 3: - FINANCIAL STATEMENTS

Audit of Accounts Report – Welsh Ambulance Services University NHS Trust

Audit year: 2024-25

Date issued: June 2025

Document reference: **4924A2025**



Contents

Contents	2
Introduction	4
Your audit at a glance	5
Materiality	6
Audit Findings	7
Audit team and ethical compliance	9
Appendix 1 – Audit risks and outcomes	10
Appendix 2 – Summary of corrections made	15
Appendix 3 – Proposed audit report	17
Appendix 4 – Letter of representation	23
Audit quality	26
Supporting you	27

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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.

Introduction



Adrian Crompton

Auditor General for
Wales

I am pleased to share my Audit of Accounts Report. The Report summarises the main findings from my audit of your 2024-25 annual report and accounts. My team have already discussed these findings with the Executive Director of Finance and Corporate Resources.

My team have substantially completed the audit work as set out in my Audit Plan dated April 2025 subject to final review of audit work and the completion of final audit procedure steps.

Since my Audit Plan, I have updated materiality to reflect the 2024-25 accounts. I have not identified any new audit risks. My

response to previously identified risks is set out in **Appendix 1**.

I am required to provide an opinion on whether the accounts have been properly prepared, and give a true and fair view, in all material aspects, and whether income and expenditure have been applied to the purposes intended. My proposed audit opinion and basis for it is outlined on page 17.

It is the responsibility of the those charged with governance, i.e. the Board to address any matters raised in my report and provide me with a Letter of Representation.

I would like to extend my gratitude to the officers and staff of Welsh Ambulance Services University NHS Trust for their cooperation throughout the audit process which has been invaluable in completing this audit effectively.

Your audit at a glance



We intend to issue an **unqualified opinion** on the accounts

See [Appendix 3](#)



There are no **other significant matters** to report

See [Audit findings](#)



There are no **uncorrected misstatements** in the accounts which we wish to draw to your attention

See [Audit findings](#)



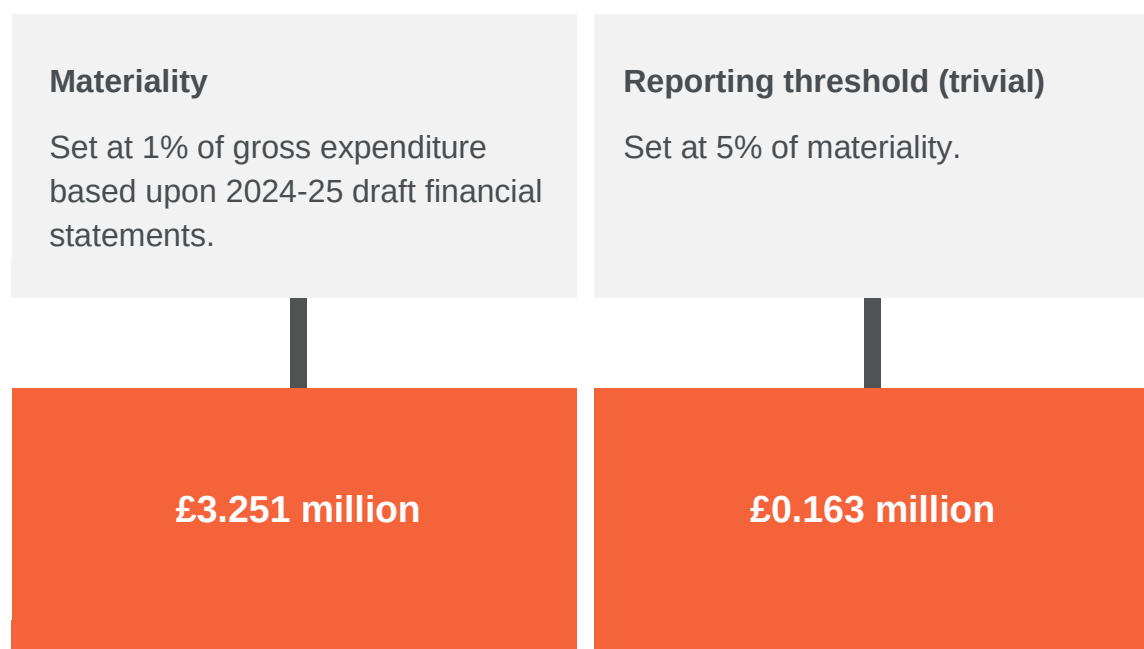
The recommendations arising from our work will be set out in an Accounts Memorandum which will be communicated with officers in due course.



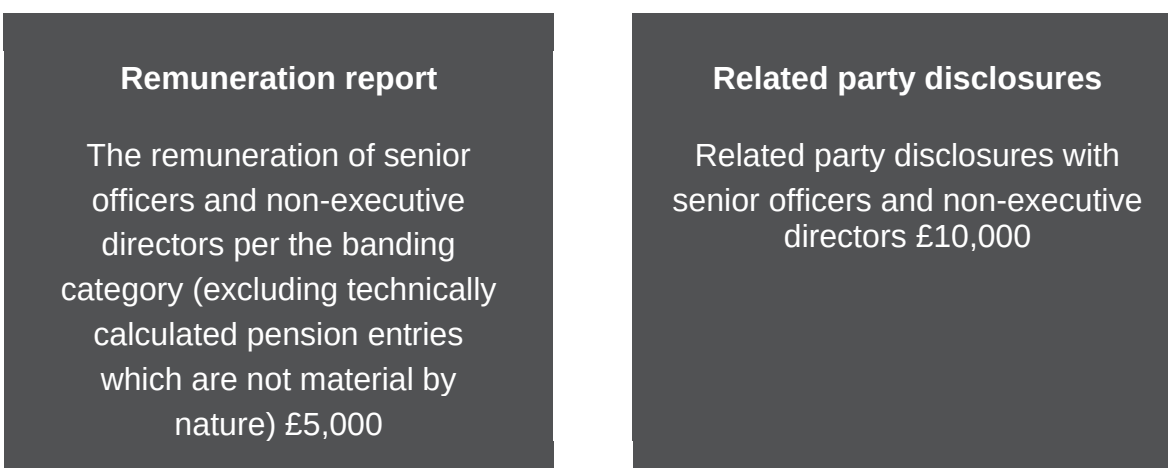
We are aiming to certify your accounts on 27 June 2025, which is ahead of the agreed deadline of 30 June 2025.

Materiality

I use professional judgement to set a materiality threshold to identify and correct misstatements that could affect users' decisions, considering both financial errors and disclosure requirements according to the applicable accounting framework and laws. My team updates materiality throughout the audit and I include in this report matters that exceed my reporting threshold, as set out below:



There are some areas of the accounts that may be of more importance to the user of the accounts. We confirm lower materiality levels for these:



Audit Findings

Misstatements

A misstatement arises where information in the accounts is not in accordance with accounting standards.

Corrected misstatements

During our audit, we identified misstatements that have been corrected by management, but which we consider should be drawn to your attention.

These are set out in **Appendix 2**.

Other significant issues

International Standard on Auditing 260 requires us to communicate with those charged with governance. We must tell you significant findings from the audit and other matters if they are significant to your oversight of Welsh Ambulance Services University NHS Trusts financial reporting process. There were no such issues identified during the audit.

Other matters

We are pleased to report that this year has seen substantial improvements in the quality of the Trust's accounts submitted for audit. This led to a significant reduction in the number of issues and misstatements reported, as evidenced in Appendix 2. This achievement is a testament to the dedicated efforts and commitment of your staff, as well as the strong working relationship developed between the audit team and your staff.

Proposed audit opinion

Audit opinion

We intend to issue an unqualified audit opinion on this year's accounts once you have provided us with a Letter of Representation (see below).

Our proposed audit report is set out in **Appendix 3**.

Letter of representation

A Letter of Representation is a formal letter in which you confirm to us the accuracy and completeness of information provided to us during the audit. Some of this information is required by auditing standards; other information may relate specifically to your audit.

The letter we are requesting you to sign is included in **Appendix 4**, the contents of which are in line with our standard request for representations.

Audit team and ethical compliance

The main members of my team who carried out the audit work, together with their contact details, are summarised in **Exhibit 1**.

Exhibit 1: my local audit team

Engagement Lead	Gareth Lucey gareth.lucey@audit.wales
Audit Manager	Yvonne Thomas yvonne.thomas@audit.wales
Audit Lead	Amy Lord amy.lord@audit.wales

Compliance with ethical standards

We confirm that:

- we have complied with the ethical standards we are required to follow in carrying out our work;
- we have remained independent of yourselves;
- our objectivity has not been comprised; and
- we have no relationships that could undermine our independence or objectivity.

Appendix 1 – Audit risks and outcomes

My Audit Plan set out the risks of material misstatement and irregularity for the audit of Welsh Ambulance Services University NHS Trust accounts.

Exhibit 2 lists these audit risks and sets out how they were addressed as part of the audit. No additional audit risks have been identified since that need to be brought to your attention.

Exhibit 2: audit risks reported previously, work done and outcome

Audit risk	Work done	Outcome
Risk of management override The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	The audit team: • tested the appropriateness of journal entries and other adjustments made in preparing the financial statements; • reviewed accounting estimates for bias; and • evaluated the rationale for any significant transactions outside the normal course of business.	My audit work did not identify any instances of management override of controls.

Risk of fraud in expenditure recognition

Due to the financial pressures faced by the Trust, we identified a significant risk that cut off would not be correctly applied to expenditure incurred around the year end.

The audit team:

- tested the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- reviewed the basis of accruals for any estimation bias;
- reviewed the year-end cut-off of expenditure; and
- tested key year balances to ensure they were appropriate and complete.

My audit work did not identify any significant issues or errors with expenditure cut off.

Remuneration Report disclosures

Due to changes in senior officer and board member posts during 2024-25, we identified a risk that these were not appropriately disclosed in the remuneration report.

My audit team:

- understood the movements in the senior management team during 2024-25;
- ensured that remuneration disclosed was consistent with supporting evidence;
- ensured that amounts paid were consistent with those approved by the Board and are in accordance with Welsh Government pay rates;
- ensured that pay was in line with regulatory requirements to support our regularity opinion; and
- ensure that disclosures were complete based on the team's knowledge and were prepared in accordance with requirements.

My work did not identify any significant issues or errors in the Remuneration Report disclosures.

Valuation of property assets

Property assets are required to be formally revalued every five years as a minimum, with indexation applied in interim years, but values may also change year on year, particularly where there are ongoing refurbishment projects resulting in subsequent expenditure being capitalised.

There is a risk that the carrying value of assets recognised in the accounts could be materially different to the current value of assets as at 31 March 2025.

The audit team:

- reviewed the indices used by management for reasonableness;
- evaluated the competence, capabilities and objectivity of the professional valuer who provide indices to management and undertake valuations as necessary;
- confirmed that indexation was appropriately applied and was correctly reflected in the financial statements; and
- tested the reconciliation between the financial ledger and the asset register

My work did not identify any issues or errors in the valuation of property assets.

Property, Plant and Equipment and Intangible Assets

We identified numerous misstatements to the figures reported in the Property, Plant and Equipment (PPE) and Intangible Assets (IA) notes in 2023-24. We identified a risk that similar misstatements could be uncovered in our 2024-25 audit which could be material in value and required amending.

The audit team:

- ensured disclosures were complete, accurate, consistent with evidence and were in accordance with requirements;

and performed detailed testing on:

- disposals to ensure they are no longer operational;
- the classification of assets categorised as PPE and IA, particularly Assets Under Construction;
- the classification of impairments in Note 15; and
- the adjustments made to the opening balances of PPE and Intangible Assets relating to the classification of impairments following clarification of the treatment within the Manual for Accounts for 2024-25.

My work did not identify any issues or errors in the figures reported for PPE and IA.

Capital investment

There was significant investment in capital projects during 2024-25. We identified a risk that capital classified as Assets Under Construction could be materially mis-stated.

The audit team:

- gained an understanding of the reasons for the peak in capital expenditure in month 12;
- performed detailed testing on a sample of additions and capital accruals; and
- reviewed whether any assets under construction required impairment.

My work did not identify any issues or errors in the figures reported for capital investment.

Related party disclosures These transactions are of high interest and are considered to be material by their nature. There is a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.	The audit team: • reviewed management's process for identifying related party relationships and associated transactions and balances; • undertook procedures to confirm the completeness of related party relationships; and • ensured disclosures are complete, accurate, consistent with evidence and in accordance with requirements.	My audit work identified related party disclosure omissions as included within the summary of corrections made in Appendix 2.
Provisions The financial statements include provisions for legal obligations, particularly in relation to clinical negligence. There is a significant degree of subjectivity and uncertainty in the measurement and valuation of these provisions. This subjectivity and uncertainty increases the risk of material misstatement	The audit team: • reviewed management's estimation process for the valuation of provisions; • considered the competence, capability and objectivity of the management experts who are prepare the estimates; and • ensured that disclosures are in accordance with HM Treasury's Financial Reporting Manual and Welsh Government's Manual for Accounts.	My work did not identify any issues or errors in the valuation of provisions.

Appendix 2 – Summary of corrections made

During our audit, we identified the following misstatements that have been corrected by management, but which we consider should be drawn to your attention.

Value of correction	Accounts area	Explanation
£193,000	Revenue from patient care activities (Note 3) and Operating expenses (Note 5.1)	A repayment of £193,000 to Joint Commissioning Committee (JCC) was incorrectly classified as expenditure, rather than a reversal of income. The following amendments were made for the classification misstatement: NWJCC/WHSSC and EASC (Note 3) decreased by £193,000 Other operating expenses decreased by £193,000 This adjustment does not affect the Trust's final net expenditure position.
£1,817,000	Trade and other payables (Note 20)	The 2023-24 Manual for Accounts was amended to require accruals, where the amounts are known, to be classified as payables, rather than accruals. The following amendments were made to correctly classify accruals in the accounts: Non-NHS accruals decreased by £1,817,000 Non-NHS payables - revenue increased by £1,817,000 This adjustment is self-contained to Note 20.

£479,000	Contingent liabilities (Note 24.1)	An updated discount rate for medical negligence claims was provided to WAST during the audit. Contingent liabilities relating to secondary care have been reduced by £479,000 to reflect this change. This adjustment is self-contained to Note 24.1.
£992,000	Losses and special payments (Note 26)	39 personal injury claims totalling £507,000, and 216 damage to property cases totalling £485,000 relating to in year payments had been omitted from note 26.1 in error. Note 26.2 has been accordingly revised for the above £992,000 (255 cases). Taking also into account the historic costs of these cases, the cumulative amount has been increased from £4,042,000 to £11,099,000. These adjustments are self-contained to Note 26.
Various	Related party transactions (Note 33)	Related party transactions with the Association of Ambulance Chief Executives have been added to the second table in this self-contained disclosure note, together with additional narrative disclosures.
Various	Various	A number of other narrative, presentational and below trivial amendments were made to supporting notes throughout the financial statements. Minor amendments were also made to the Annual Report.

Appendix 3 – Proposed audit report

The Certificate and report of the Auditor General for Wales to the Senedd

Opinion on financial statements

I certify that I have audited the financial statements of Welsh Ambulance Services University NHS Trust for the year ended 31 March 2025 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Cash Flow Statement and the Statement of Changes in Taxpayers' Equity and related notes, including a summary of material accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- give a true and fair view of the state of affairs of Welsh Ambulance Services University NHS Trust as at 31 March 2025 and of its surplus for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of financial statements and regularity of public sector bodies in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the trust in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for Welsh Ambulance Services University NHS Trust is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion

thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers' directions; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability report.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- I have not received all the information and explanations I require for my audit;
- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns;

- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records;
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the annual report and financial statements as a whole are fair, balanced and understandable;
- ensuring the regularity of financial transactions;
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; and
- assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors and Chief Executive anticipate that the services provided by the Trust will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud

or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, the head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to Welsh Ambulance Services University NHS Trust's policies and procedures concerned with:
 - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
 - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
 - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in management override and expenditure recognition;
- Obtaining an understanding of Welsh Ambulance Services University NHS Trust's framework of authority as well as other legal and regulatory frameworks that the Welsh Ambulance Services University NHS Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of Welsh Ambulance Services University NHS Trust;
- Obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, the Audit and Risk Assurance Committee and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board;

- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Welsh Ambulance Services University NHS Trust's controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report

I have no observations to make on these financial statements.

Adrian Crompton
Auditor General for Wales
27 June 2025

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Appendix 4 – Letter of representation

Auditor General for Wales

Wales Audit Office

1 Capital Quarter

Cardiff

CF10 4BZ

26 June 2025

Representations regarding the 2024-25 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Welsh Ambulance Services University NHS Trust for the year ended 31 March 2025 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
 - observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
 - make judgements and estimates on a reasonable basis;

- state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
 - prepare them on a going concern basis on the presumption that the services of Welsh Ambulance Services University NHS Trust will continue in operation.
- ensuring the regularity of any expenditure and other transactions incurred; and
- the design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- full access to:
 - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
 - additional information that you have requested from us for the purpose of the audit; and
 - unrestricted access to staff from whom you determined it necessary to obtain audit evidence;
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- our knowledge of fraud or suspected fraud that we are aware of and that affects Welsh Ambulance Services University NHS Trust and involves:
 - management;
 - employees who have significant roles in internal control; or
 - others where the fraud could have a material effect on the financial statements;
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others;
- our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements;

- the identity of all related parties and all the related party relationships and transactions of which we are aware; and
- our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions.

Representations by the Board

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by the Board on 26 June 2025.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:
Jason Killens
Chief Executive
Date: 26 June 2025

Signed by:
Colin Dennis
Board Chair
Date: 26 June 2025

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our [Audit Quality Report 2024](#).



Our People

- Selection of right team
- Use of specialists
- Supervisions and review



Arrangements for achieving audit quality Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support



Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

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Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.



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Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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





GIG
CYMRU
NHS
WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

AGENDA ITEM No	14
OPEN or CLOSED	Open
No of ANNEXES	2

Committee Monitoring Report and Priorities Update 2025-26

MEETING	Audit, Risk and Assurance Committee
DATE	24 June 2025
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 Audit, Risk and Assurance Committee (ARAC) on progress against the priority it set for 2025/26 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 review of the Trust Governance Practice Notes scheduled for the quarter 1b meeting is not required at this time as the review dates for the suite of notes is April 2026.

RECOMMENDATION: -

2. **The Committee is asked to: -**
To note the update on the Cycle of Business Monitoring Report for the Committee and the position against its annual priority.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

REPORT APPENDICES

Annex 1 – ARAC Cycle of Business Monitoring Report – June 2025

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 2025/26 AND CYCLE MONITORING REPORT

SITUATION

3. This report updates the Committee on progress against the priorities it set for 2025/26 and progress against the agreed Cycle of business. There are no matters to escalate to the Committee from the Cycle of Business; however, it is noted that the review of the Trust Governance Practice Notes scheduled for the quarter 1b meeting is not required at this time, as the review dates for the suite of notes is April 2026.

BACKGROUND

4. 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 2025 and will be tracked quarterly.
5. The Committee's cycle of business was approved by the Committee in May 2025. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.
6. 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.
7. 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

8. The Committee priority for 2025-26 and progress against it is as follows:



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Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

Priority	Progress
Monitoring progress of the committee effectiveness review 'part II' throughout 2025-26 (as set out at the 01 May 2025 ARAC) with respect to the committee delegations, membership and meeting frequency.	This work is being progressed by the Director of Corporate Governance/Board Secretary, with the project plan agreed.

RECOMMENDATION: -

9. The Committee is asked to: -

To note the update on the Cycle of Business Monitoring Report for the Committee and the position against its annual priority.

PAPER	PRE or POST C'EE FORUM	FREQUENCY	Q1a	Q1b	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
AUDIT, RISK AND ASSURANCE COMMITTEE - CYCLE OF BUSINESS 2025/26										
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	
Annual report	ELT and Board	Annually						BS	Endorsement	
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	
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	Relevant directors to be in attendance for limited assurance reviews
Audit Wales										
Audit Plan	ELT and Board	Annually						Audit Wales	Review	SFI 3.4.1 AC must ensure cost efficient external audit service is delivered; SFI 3.4.3 AC to review plan and associated costs. Noted to Board
Update report	N/A	Quarterly						Audit Wales	Assurance	
Annual Audit Report	ELT and Board	Annually						Audit Wales	Assurance	Audit report for calendar year. Copy to Board in AAA
Structured Assessment	ELT and Board	Annually						Audit Wales	Assurance	May also be presented at other times depending upon audit plan
Other Non-Core Reports	ELT and Board	Various						Audit Wales	Assurance	Non-core reports are those outside of the Structured Assessment work and are included in the Audit Plan
Losses & Special Payments/Single Tender Waivers										
Quarterly lossess and special payments report	N/A	Quarterly						EDOF	Approval	See Note 1
Tender update report and single tender waiver request	N/A	Quarterly						EDOF	Assurance	Closed session
Counter fraud										
Counter fraud update report	N/A	Quarterly						EDOF	Assurance	Closed session. See Note 6
Counter fraud annual report	ELT	Annually						EDOF	Assurance	Closed session. See Note 6 Not to go to Board - only ARAC
Counter fraud update work plan	ELT	Annually						EDOF	Approval	Closed session. See Note 6
Standing Orders & Standing Financial Instructions										
Standing Orders & Standing Financial Instructions	ELT and Board	Annually						BS	Endorsement	Q4 24-25: Revised for 2025, however SFI changes will be coming forward for Q2 ARAC 25-26.
Breach of Standing Orders & Standing Fin. Instructions	ELT	Ad Hoc						BS	Discussion/Assurance	
Governance Practice Notes	ELT	Annually						BS	Approval	Q1b: Review not required in 2025; reference in the monitoring report update.
Whistleblower, Declarations, Gifts & Hospitality										
Annual report on declarations of interest	ELT	Annually						BS	Assurance	
Report on gifts and hospitality	ELT	Annually						BS	Assurance	
Whistleblower (speaking up safely) report	TBC	TBC						BS	TBC	See Note 2
Other										
Near Miss Report	QUEST	Annually						BS	Assurance	See Note 3
Policy										
Policy report	ELT	Quarterly						BS	Assurance	Position on policies including those outstanding for review etc. See Note 4
Policies	Policy Group	Ad Hoc						BS	Approval	Policies within the purview of this Committee - see Note 5
Financial procedures	TBC	Ad Hoc						EDOF	Approval	SFI 1.1.3 all financial procedures must be approved by the EDOF and Audit Committee
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	This includes the annual report and amendments to TORs for all Board Committees and WASPT
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	
Mid-year review of committee operating arrangements	n/a	Annually						BS	Review	
Integrated Governance Programme Progress Update	n/a	Bi-annually						BS	Assurance	Added on 160625
Review of Governance Practice Notes	n/a	Biennially						BS	Approval	Added on 100625
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
- Ad 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 (SUS)	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. The Speaking Up Safely framework is overseen on behalf of the board by the People and Culture Committee. Assurance on the whistleblowing (or speaking up safely) process and arrangements for special investigations to come to Audit Committee via a AAA from the Chair of the People and Culture Committee. See pages 39 and 40 of Audit Committee Handbook
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. Assurance to ARAC via AAA from chair of QUEST annually. Audit Committee 25 July 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.
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
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.