Bundle Audit, Risk and Assurance Committee (Open) 23 June 2026

Agenda attachments
00 Agenda

0 09:30 - OPENING ITEMS

1 Chair's Welcome, Apologies and Quorum

2 Declarations of Interest
Item 02 Board Member Register of Interests - 10 June 2026

3 Minutes of the last meeting held on 28 April 2026 (Confirmation of recording/transcript deletion of previous meeting)
Item 03 2026-04-28 unconfirmed ARAC PUBLIC Minutes

4 Action Log and Matters Arising
Item 04 Action Log

4.1 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:35 - 2025-26 Annual Accounts and Annual Report and Recommendation to Trust Board

5.1 2025-26 Annual Audited Accounts
Item 05.1 Annual Accounts 2025-26
Item 05.1 Annex 1 Annual Accounts 2025-26

5.2 2025-26 Annual Report
Item 05.2 Annual Report 2025-26
Item 05.2 Annex 1 2025-26 combined annual report for ARAC 160626

5.3 Audit of Accounts Report 2025-26 (Inc. Letter of Representation)
Item 05.3 Audit of Accounts Report 2025-26

6 10:20 - Internal Audit

6.1 Annual Head of Internal Audit Opinion
Item 06.1 Head of Internal Audit Opinion and Annual Report 2025-26

6.2 Internal Audit Reports

6.2.1 Follow Up Review (No overall assurance assigned to this work)
Item 06.2.1 Follow Up Review Final Internal Audit Report

6.2.2 Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management (Reasonable Assurance)
Item 06.2.2 CPAS Group Governance Workflow Final Internal Audit Report

6.2.3 Vehicle Replacement Programme (Reasonable Assurance)
Item 06.2.3 Vehicle Replacement Programme Final Internal Audit Report

6.2.4 Data Management Practices / Devolved Data (Reasonable Assurance)
Item 06.2.4 Data Management Practices Devolved Data Final Internal Audit Report

6.2.5 Estates Assurance: Fire Safety (Reasonable Assurance)
Item 06.2.5 Fire Safety Internal Audit Report

6.2.6 High Risk Record Policy (Reasonable Assurance)
Item 06.2.6 High Risk Record Policy Final Internal Audit Report

6.3 11:20 - COMFORT BREAK

7 11:35 - Audit Wales Audit Risk and Assurance Committee Update June 2026

Item 07 Audit Wales Audit Risk and Assurance Committee Update (June 2026)

8 12:05 - Audit Wales Digital Deep Dive (DEFERRED)

9 12:05 - Risk Management and Board Assurance Framework Report
Annex 4 Board Assurance Framework is available to view in the Reading Room
Item 09 Risk Management Report
Item 09 Annex 5 Trending Data Mar 2023-May 2026

10 12:20 - Audit Tracker Reporting and Q4 2025/26 Update
Item 10 Audit Tracker 3.0 2025-26 Q4 (Jan-Mar26)
Item 10 Annex 1 2025-26 Q4 (Jan-Mar26)

11 12:35 - Losses and Special Payments
Item 11 Losses and Special Payments
Item 11 Annex 1 Losses and Special Payments 2025-26
Item 11 Annex 2 Losses and Special Payments 2026-27

12 12:45 - Integrated Governance Programme
Item 12 Integrated Governance Framework
Item 12 Annex 1 WAST Integrated Governance Framework - Overview v1.0

12.1 13:05 - CONSENT ITEMS

13 Audit Risk and Assurance Committee AAA Highlight Report 28 April 2026 (no alerts)
Item 13 ARAC AAA Report 28 April 2026

14 All Wales Audit Committee Chairs (AWACC) Meeting Notes 1 June 2026
Item 14 AWACC Copilot Meeting notes 1 June 2026

14.1 13:05 - CLOSING ITEMS

15 Reflections

16 Any Other Business

17 Date & Time of the Next Meeting: 3 September 2026 @ 09:30am

Length of Meeting:	03:40		[PUBLIC] AUDIT, RISK AND ASSURANCE COMMITTEE - 23 JUNE 2026					Deadline for Papers: 12 June 2026		Last good practice Exec Review: 10 June 2026
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**	**Notes**
			OPENING ITEMS							
09:30	00:05	1	Chair's Welcome, Apologies 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 held on 28 April 2026 **(Confirmation of recording/transcript deletion of previous meeting)**	Paper	Approval	Standing	n/a	Chair	n/a	
		4	Action Log and Matters Arising	Paper	Discussion	Standing	n/a	Chair	n/a	
			FOR APPROVAL, ASSURANCE AND DISCUSSION							
09:35	00:45	5	2025-26 Annual Accounts and Annual Report and Recommendation to Trust Board 5.1 25-26 Annual Audited Accounts 5.2 2025-26 Annual Report 5.3 Audit of Accounts Report, 2025-26 Accounts (Inc. Letter of Representation)	Paper	Endorsement	CoB	FinCor	Chris Turley Trish Mills Audit Wales	Alex Payne, Ed Roberts, Jill Gill	
10:20	01:00	6	**Internal Audit** 6.1 Head of Internal Audit Opinion and Annual Report 2025-26 6.2 Internal Audit Reports: 6.2.1 Follow Up Review *(No overall assurance assigned to this work)* (TM) 6.2.2 Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management *(Reasonable Assurance)* (AS) 6.2.3 Vehicle Replacement Programme *(Reasonable Assurance)* (CT) 6.2.4 Data Management Practices / Devolved Data (*Reasonable Assurance*) (JS) 6.2.5 Estates Assurance: Fire Safety *(Reasonable Assurance*) (CT) 6.2.6 High Risk Record Policy *(Reasonable Assurance)* (LB/JB)	Paper	Assurance	CoB	Internal Audit	Osian Lloyd	Felicity Quance	
11:20	00:15		COMFORT BREAK							
11:35	00:30	7	Audit Wales Audit Risk and Assurance Committee Update June 2026	Paper	Assurance	CoB	External Audit	Fflur Jones	n/a	
12:05	00:00	8	Audit Wales Digital Deep Dive - **DEFERRED**	Paper	Assurance	AdHoc	External Audit	Fflur Jones	n/a	
12:05	00:15	9	Risk Management and Board Assurance Framework Report	Paper	Assurance	CoB	CorGov	Julie Boalch	n/a	
12:20	00:15	10	Audit Tracker Reporting and Q4 2025/26 Update	Paper	Assurance	CoB	CorGov	Trish Mills	Lisa Trounce	
12:35	00:10	11	Losses and Special Payments	Paper	Assurance	CoB	FinCor	Chris Turley, Ed Roberts	Jillian Gill	
12:45	00:20	12	Integrated Governance Programme	Paper	Assurance	Cob	CorGov	Trish Mills	Julie Boalch, Alex Payne	
			CONSENT ITEMS							
13:05	00:00	13	Audit Risk and Assurance Committee AAA Highlight Report 28 April 2026 (no alerts)	Paper	Information	CoB	CorGov	Chair	Sarah Harland	
	00:00	14	All Wales Audit Committee Chairs (AWACC) Meeting Notes 1 June 2026	Paper	Information	CoB	CorGov	Chair	Sarah Harland	
			CLOSING ITEMS							
		15	Reflections	Verbal	Discussion	Standing	n/a	Chair	n/a	
13:05	00:05	16	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a	
		17	Date & Time of the Next Meeting: 3 September 2026 @ 09:30am	Verbal	Information	Standing	n/a	Chair	n/a	
13:10	**03:40**		**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
Ed Roberts	Head of Financial Business Intelligence and Capital Planning
Chris Turley	Executive Director of Finance & Corporate Resources

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended
AHMAD, Umar Afthab DR	**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	GP Partner at Plains View Surgery, Nottingham	Financial Interest	2014	
		Primary Care Network Clinical Director for Arrow Health, Nottingham	Financial Interest	2019	
		Non-executive Director (appointed company director) for Primary Integrated Community Services Ltd, Nottingham and small shareholder [Company number 08763136]	Financial Interest	2023 and 2016	
		Owner and company director of Travel Jab Guru Ltd – online medical travel advice [Company number 14685908]	Financial Interest	2023	
		Local Medical Committee Member	Financial Interest	2019	
		Nottingham Integrated Care Board Cardiovascular Disease and Stroke Prevention Clinical Design Authority Lead	Financial Interest	2025	
		Associate Non-executive Director Nottinghamshire University Hospital Trust (non-voting member of the board)	Financial Interest	2024	
BEESLEE, Jayne	**Non-Executive Director** * Chair of Finance and Performance Committee * Member of the Remuneration Committee * Member of the Remuneration Committee	Employment fro interim assignments via Public Sector Resourcing (an agency) regarding the rev iew of major UK Government programmes (remunerated nex of tax via an umberella company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023	
		Governor on the Finance and General Purposes Committee of Cardiff and Cale Further Education College	Non-Financial Personal	01 February 2024	
		Fellow Chartered Institute of Persennel and 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	
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	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021	
		Trustee of Action for Children Pension Board	Position in Charity or Voluntary Organisation		
		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	
		Chair - Taff Housing Association	Any Other Interest	17 July 2025	
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303	Non-Financial Professional	01 March 2024	
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024	
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Group Chair of South Central Ambulance Service NHS Foundation Trust and South East Coast Ambulance Service NHS Foundation Trust	Directorships	27 March 2026	
		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	
DURRANT, Penny	**Service Manager, Clinical Support Desk (Nursing)**	Nil Declaration		30 May 2026	
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	Chief Executive Officer (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019	
		Non-Executive Board Member at Beacon Housing (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 - Moorlands Property Ltd	Directorships	16 August 2022	
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020	
		Companty Director - Springfield Property Lettings Ltd	Directorships	16 August 2022	
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021	
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020	
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022	
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020	
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	Directorships	12 March 2020	

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended
EVANS, Bethan [continued]	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022	
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	Directorships	27 April 2022	
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022	
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022	
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022	
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022	
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024	
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023	
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024	
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024	
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024	
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024	
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024	
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024	
		Company Director - The Mountains Property Ltd	Directorships	09 December 2024	
		Longhope Property Ltd	Directorships	12 February 2026	
		My Choice Healthcare England Ltd	Directorships	26 August 2025	
		My Choice Healthcare Ltd	Directorships	26 August 2025	
		Glyncornel Care Ltd	Directorships	16 August 2022	
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	
HUTCHINGS, Hayley	**Non-Executive Director** * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Emeritus Professor, Swansea University	Non-Financial Professional	31 May 2025	
		Consultant Advisor to the FASAR Trial, Nottingham Trent University	Financial Interest	25 March 2026	
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	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	
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**	Chartered Fellow of the CIPD		2005	
MARSH, Rachel	**Deputy Chief Executive/Executive Director of Strategy,**	Nil Declaration			
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration			
PARRY, Hugh	**Trade Union Partner**	Nil Declaration			
ROBERTS, Edward	**Interim Finance Director (from 09 September 2025)**	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	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021	
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024	
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024	
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025	
		Co-opted into the BCS Community Board	Any Other Interest	12 August 2025	11 August 2026
		CHIME (College of Healthcare Information Management Executives) Digital Health Fellowship - UK Cohort 2026	Non-Financial Professional	07 May 2026	
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**	Nil Declaration			
TURNER, Damon	**Trade Union Partner**	Nil Declaration			

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended
Executive Director of Quality and Nursing [from 01 August 2022]	**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	
		Vice Chair - Royal College of Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	03 February 2025	
WOOD, Emma	**Chief Executive (from 01 October 2025)**	Chartered Fellow of CIPD (Chartered Institute of Personnel and Development)	Non-Financial Professional	2000	
		Member of Yoga Professional Alliance	Non-Financial Personal	July 2025	
		Part-time Yoga Teacher at Burnham Swim and Sports Academy Leisure Centre	Financial Interest	July 2025	
		Sub/Relief Yoga Teacher at Omni Studio, Worle, North Somerset	Financial Interest	04 April 2026	

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

UNCONFIRMED MINUTES OF THE PUBLIC MEETING OF THE AUDIT RISK AND ASSURANCE COMMITTEE ON TUESDAY 28 APRIL 2026 HELD AT THE CARDIFF MAKE READY DEPOT AND VIA TEAMS

Meeting started at 09:30

PRESENT

Peter Curran	Non-Executive Director and Committee Chair
Dr Umar Ahmad	Non-Executive Director
Ceri Jackson	Non-Executive Director
Judith Bryce	Assistant Director of Operations
Christian Fox	Trade Union Partner
Wendy Herbert	Deputy Director of Quality & Putting Things Right
Fflur Jones	Audit Wales *(left at 10:43am)*
Carl Kneeshaw	Director of People
Trish Mills	Director of Corporate Governance/Board Secretary
Osian Lloyd	Head of Internal Audit, NWSSP Internal Audit
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner
Carl Window	Local Counter Fraud Manager

ATTENDEES

Sarah Harland	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Yvonne Thomas	Audit Wales *(left at 10:43am)*
Felicity Quance	Deputy Head of Internal Audit
AnnaMaria Williams	Corporate Governance Officer *(Observing)*

APOLOGIES

Julie Boalch	Assistant Director of Corporate Governance and Risk

DRAFT

OPENING ITEMS

1. CHAIR'S WELCOME, APOLOGIES AND QUORUM

1.1 The Chair extended a warm welcome to Dr Umar Ahmad, newly appointed non-executive director. Apologies were received as set out above. Quorum was confirmed.

2. DECLARATIONS OF INTEREST

2.1 There were no other declarations recorded.

3. MINUTES OF THE LAST MEETING HELD ON 2 MARCH 2026

3.1 The minutes from the public meeting held on 2 March 2026 were received and approved.

4.1 ACTION LOG & MATTERS ARISING

4.1.1 The action log was reviewed and discussed, with updates added to the log.

4.2 COMMITTEE AAA HIGHLIGHT REPORT: 2 MARCH 2026

4.2.1 The AAA highlight report from the meeting held on 2 March 2026 was received.

5. 2025/2026 ANNUAL REPORTS FROM COMMITTEES

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

5.1 The Chair advised that the main purpose of this meeting is specifically to enable scrutiny of the 2025/26 annual effectiveness reviews of all committees on behalf of the Trust Board. The Chair outlined the Audit Risk and Assurance Committee's (ARAC) role in reviewing the reports, identifying key issues, and determining any observations or matters for escalation to the board, including proposed changes to committee terms of reference.

5.2 Trish Mills confirmed this item represents the final stage of the 2025/26 quality governance (effectiveness) review process. Trish advised that, although a light-touch approach had been intended, the process had been more protracted due to work undertaken by the ARAC subgroup on proposals to streamline committee structures. Effectiveness reviews had been completed for all committees, with the exception of the Welsh Ambulance Service Partnership Team (WASPT), which has been deferred to June to allow further engagement from members.

5.3 It was noted that all committees had approved their annual reports and minor revisions to terms of reference, which had already been considered by ARAC and the board. The reports provided assurance on the effectiveness of committee governance arrangements and did not identify issues beyond those already addressed through the streamlining work, with reports due to be presented to trust board in May.

5.4 The committee also noted the context of the forthcoming Good Governance Institute (GGI) review, which, although not fully aligned with the effectiveness review timetable, would inform future board and committee arrangements. Concerns were raised regarding low response rates to the effectiveness review surveys, and it was acknowledged that questionnaire fatigue remained a challenge, although response rates were being tracked and alternative approaches were being considered to improve engagement and reduce survey fatigue.

5.5 The committee reviews were discussed and scrutinised as follows:

5.5.1 **Academic Partnership Committee (APC)**
The committee noted that the APC was in the process of being wound down, having fulfilled its core purpose in supporting the trust to achieve 'University Trust' status, although it would continue to meet during 2026/27. The Chair sought clarification regarding responsibility for oversight of the research portfolio. Trish confirmed that APC's current focus was solely research and advised that a proposed transfer of research oversight to the Finance and Performance Committee had been deferred pending the outcome of the GGI review. Trish also confirmed that in the interim, APC would continue to hold responsibility for research oversight.

5.5.2 **Charity Committee**
The committee noted that the Charity Committee had continued to develop positively over the past 12 - 18 months, with no need for a fundamental change to its current arrangements. The Chair commented that the committee remained on a development journey and that governance arrangements should remain proportionate and sufficiently flexible to reflect future direction.

Ceri Jackson highlighted two strategic concerns; capacity to deliver the charity's ambitions in the context of financial pressures; and the ongoing need for clarity around managing conflicts of interest and trustee responsibilities, noting the importance of members being clear about the role they were undertaking at any given time. Trish Mills confirmed that charity governance arrangements had strengthened significantly following the introduction of dedicated resource. Trish noted the additional complexity arising from the committee's sub-groups but confirmed that the charity's governance arrangements would continue to be reviewed as the charity evolves.

5.5.3 **Finance and Performance Committee (FPC)**

The committee noted positive feedback on the effectiveness of the FPC, recognising ongoing work to strengthen performance reporting, including development of the monthly integrated quality and performance report (MIQPR) suite of metrics. The Chair highlighted the potential future expansion of the committee's remit, including oversight of research and commercialisation activity, subject to the outcome of the GGI review.

Chris Turley highlighted significant contextual challenges arising from ongoing financial pressures, including anticipated reductions beyond 2025/26. Chris emphasised concerns regarding capacity and skills to scrutinise certain portfolio areas within the committee's remit, particularly estates, environmental sustainability and decarbonisation, noting limited organisational resource and increasing risk in these areas.

Trish Mills noted that the committee met bi-monthly, in alignment with the board, and that this often resulted in duplication of reporting between FPC and the board. Trish advised that significant changes were anticipated from 2026/27 onwards to support a shift towards more strategic focus, increased delegated authority and reduced operational detail. Trish confirmed that skills gaps and associated risks would be considered through the ARAC subgroup's work on the board skills matrix, including options to mitigate gaps through training or development, with prioritisation based on risk.

5.5.4 **People and Culture Committee (PCC)**

The committee noted that the PCC had operated effectively during 2025/26, with positive feedback reflected in the annual report. Ceri Jackson, Chair of PCC, emphasised the committee's ambition to move towards a more strategic focus, acknowledging that reducing operational detail would require a cultural and behavioural shift and increased confidence in the underlying governance arrangements. Carl Kneeshaw supported this view, advising that while good

progress had been made, further work was required to strengthen strategic, system-level considerations and alignment with the People and Culture Plan and wider trust objectives.

Trish Mills confirmed that work was underway to refresh internal governance and delivery group arrangements reporting to the Executive Leadership Team (ELT), with assurance to be provided to ARAC to support committees in moving away from operational detail. Trish advised that a paper outlining these arrangements would be presented to ARAC in June.

5.5.5 **Quality, Patient Experience and Safety Committee (QuEST)**
The committee noted positive feedback on the effectiveness of the QuEST committee during 2025/26. The Chair and members acknowledged that QuEST was a particularly challenging committee due to the complexity and seriousness of patient safety issues and wider NHS system pressures.

Ceri Jackson highlighted that QuEST meetings were lengthy and required a careful balance between providing sufficient assurance on high-harm risks and progressing towards a more strategic focus. Ceri emphasised the importance of confidence in the effectiveness of governance and delivery arrangements below committee level to enable reduced focus on operational detail. Wendy Herbert supported this view, noting the difficulty of stepping back from detail given current system pressures and the need to maintain assurance regarding patient outcomes and experience.

Trish Mills advised that while QuEST meetings appeared long, actual meeting time averaged approximately four hours per quarter, with appropriate breaks. Trish confirmed that attendance from members was strong, but acknowledged variability in officer attendance due to operational and leadership challenges. Trish agreed that officer attendance should be highlighted in the AAA highlight report to the board, to reinforce the importance of consistent representation and committee-level

5.5.6 **Remuneration Committee (RemCom)**
The committee noted that the RemCom operated effectively, with meetings described as short, focused and proportionate given their specific remit. It was acknowledged that all non-executive directors were members of RemCom, which reflected good practice, particularly during a period of leadership change, although attendance varied.

Trish confirmed that it had been agreed at RemCom that approved committee minutes would no longer be routinely included on the board agendas, as they were publicly available on the trust website and assurance was instead provided through committee AAA reports.

Members discussed whether the current RemCom membership model and attendance expectations remained appropriate, noting that this issue would be considered in the wider context of non-executive director commitments and was likely to be informed further by the forthcoming GGI review.

5.5.7 **Audit Risk and Assurance Committee (ARAC)**

The committee noted that the ARAC had taken a different approach to its effectiveness review, using the National Audit Office (NAO) toolkit and undertaking ongoing review through quarterly meetings involving non-executive directors and senior officers. The Chair advised that this approach enabled continuous improvement throughout the year, achieved full engagement and supported timely identification and resolution of issues.

The Chair highlighted that skills gaps had been identified and were being actively considered, with mitigation options including targeted training and development. The Chair also raised a concern about the timing of receipt internal and external audit reports by the committee, noting that it was sub-optimal for such reports to be considered by other committees before ARAC; however the practical constraints were acknowledged. Members supported the continuous improvement approach and agreed that, while pragmatism was required, clarity was needed where audit reports had not first been scrutinised by ARAC. Trish confirmed that the audit handbook was being reviewed to clarify the respective roles of ARAC and other committees and advised that consideration was being given to improving information flow to support the ARAC in fulfilling its role/function.

5.6 The Chair confirmed that ARAC was satisfied to endorse the annual reports from all committees for 2025/26, including the ARAC annual report for 2025/26 and to approve the cycle of business for 2026/27. The Chair thanked officers, committee chairs and members for the extensive work undertaken and highlighted the value of the discussions in identifying areas for continued improvement, particularly in relation to skills, strategic focus and the flow of assurance from committees to the board.

The committee:

1. **Endorsed the suite of 2025/26 board committee annual reports, noting that all committee quality and governance reviews have been completed, except for the Welsh Ambulance Services Partnership Team (WASPT) review;**
2. **Endorsed the Audit, Risk and Assurance Committee (ARAC) 2025/26 annual report;**
3. **Approved the ARAC 2026/27 cycle of business, confirming that the committee's own annual effectiveness review has been completed in line with the National Audit Office toolkit; and**
4. **Noted the actions arising from the ARAC annual review, including those relating to communication, skills and experience, and board skills matrix development, and that these actions continue to be progressed through the ARAC sub-group with oversight by ARAC.**

6.1 INTERNAL AUDIT PROGRESS REPORT

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

6.1.1 Osian Lloyd provided an update on progress against the 2025/26 internal audit plan. Osian advised that twelve audit reports had been finalised, three were in draft, and the remaining audits were in progress, with no material concerns identified regarding overall delivery of the plan. Osian noted that some planned reports, including digital audits, had not been finalised due to capacity pressures within the digital senior leadership team, resulting in a higher volume of reports anticipated for the next ARAC meeting.

6.1.2 Osian further reported that follow up validation work was progressing well, with the majority of sampled actions confirmed as closed and a small number requiring additional evidence. Osian advised that approximately 70% of recommendations due for closure by December had been completed, which was comparable with performance across NHS Wales. Osian confirmed that a consolidated annual internal audit summary report would be presented at the June meeting and noted that all internal audit KPIs were currently rated green.

6.1.3 The Chair welcomed the progress reported and noted the improvement reflected by all internal audit KPIs being rated green. The Chair suggested that future progress reporting might benefit from clearer visual presentation to aid understanding and sought assurance that the internal audit plan would be completed by June. Osian confirmed that delivery of the plan remained on track, acknowledging capacity pressures affecting one audit area, but advising that mitigating arrangements were in place and that no overall slippage was anticipated.

6.1.4 Chris Turley expressed concern regarding the inclusion of assurance ratings for draft internal audit reports within the progress update to the committee. Chris felt that it was inappropriate for provisional assurance opinions to be included, specifically referencing the ongoing fire safety audit, as findings and conclusions could change following completion of the audit fieldwork/review. Chris therefore requested that draft reports be clearly distinguished or excluded from assurance reporting until finalised, to avoid potentially misleading conclusions. This was acknowledged by Internal Audit colleagues.

6.1.5 Trish Mills cautioned that the increasing volume of actions and supporting evidence arising from internal audit reports was placing a significant resource burden on directorates and the Corporate Governance Team. Trish noted that even audits receiving reasonable assurance were generating a large number of management actions and evidence requirements, which risked becoming disproportionate and could impact overall performance in tracking and validating actions. Trish emphasised the need for greater proportionality in the number of actions and evidence requests.

6.1.6 Felicity Quance acknowledged the feedback and advised that recent changes to the internal audit report template may have had unintended consequences. Felicity confirmed that the issues raised had been fed back internally and that a working group was being convened to review the report template and consider refinements, including clearer signposting of key findings. Osian supported this position, confirming that the concerns had been recognised and were not unique to the trust. Osian advised that work was underway to review reporting approaches to ensure findings and actions were clearer, more concise and proportionate, while still providing appropriate assurance.

The committee noted the Internal Audit Progress Report.

6.2 INTERNAL AUDIT REPORTS

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

6.2.1 **Risk Management and Board Assurance Framework**

Osian Lloyd presented the annual risk management and assurance audit, confirming a **reasonable assurance** opinion over the trust's arrangements for identifying, managing and reporting strategic and principal risks. Osian advised that the board assurance framework (BAF) continued to provide good coverage of principal risks, supported by regular review through established governance structures, including board and committee oversight. Osian highlighted improvements in the maturity of risk management, including clearer governance arrangements, alignment of risk

appetite statements to strategic objectives, and more dynamic movement in risk scores reflecting mitigation activity. Osian noted that historical emphasis on corporate risks over strategic risks had been recognised, and addressed through the development of a new strategic risk approach. Osian also highlighted progress towards implementation of an in-house electronic risk management system, which was expected to reduce reliance on manual processes. Osian reported two accepted findings relating to refinement of the risk management policy and improvements to the tracking and updating of BAF action plans, noting that these issues were being addressed.

Trish Mills welcomed the reasonable assurance opinion and advised that the trust was entering the next stage of maturity in risk management, moving from a principally operational BAF towards a more strategic BAF aligned to long term objectives. Trish confirmed that work was underway to embed strategic risks, improve clarity around risk tolerance and strengthen the linkage between completed actions, controls and risk score movement. Trish also outlined progress on developing an in-house electronic risk management system, noting that while the ambition was to implement from summer 2026, delivery would be phased and piloted due to internal resource constraints.

The Chair welcomed the positive assurance and acknowledged that the trust was on a continued improvement journey, noting that further development would be required as the strategic BAF was embedded. Ceri supported this view, commenting that the report reflected progress in the right direction and recognising that further refinement would be needed as the organisation continued to mature its strategic risk management arrangements.

6.2.2 **Welsh Language Standards**

Felicity Quance presented the internal audit report on Welsh language standards, confirming a **reasonable assurance** opinion over the trust's arrangements for compliance. Felicity advised that the trust had strong foundations in place, including clear executive leadership, designated Welsh language roles, comprehensive policies and good staff engagement through networks and training initiatives. Felicity noted that statutory reporting requirements had been met, including timely publication of the Welsh language annual report, and that compliance across service delivery standards was generally strong.

Felicity highlighted three medium-priority findings, including limited evidence of consistent monitoring and embedding of the standards across services, weaknesses in governance and operation of the Welsh Language Advisory Group, and inconsistent recording and escalation of Welsh language related complaints, particularly where issues were resolved locally.

Felicty also noted non-compliance with Standard 110A, relating to the delayed assessment and publication of the five-year Welsh language plan, acknowledging capacity constraints, but noting that recent additional administrative support should strengthen future delivery.

Members welcomed the reasonable assurance opinion and recognised the progress made, particularly given the size and dispersion of the workforce. Ceri Jackson highlighted concerns regarding the effectiveness of the Welsh Language Advisory Group, questioning whether attendance and engagement reflected sufficient organisational priority, and emphasised the importance of having the right level of commitment and ownership beyond governance structures alone.

The Chair reflected on the importance of enabling patients to communicate in their first language wherever possible, particularly in high stress clinical situations, and sought assurance that learning from lived experience and complaints was being captured and acted upon. Members acknowledged that complaint volumes were low but agreed that continued focus on awareness, culture and proportionality was important.

6.2.3 **Capacity Management Plan (CMP) (Ambulance Care)**

Felicity Quance presented the internal audit report on the CMP, confirming a **reasonable assurance** opinion over its application within the non-emergency patient transport service (NEPTS), while noting that the CMP was operating under sustained system pressure and was activated frequently. Felicty advised that the audit identified six findings, including one high priority finding, relating primarily to the consistency and transparency of decision making and the adequacy of audit trails supporting CMP activation and journey cancellation decisions.

Felicity highlighted that reliance on professional judgement would benefit from clearer, more objective thresholds and improved recording of decision rationales. Felicity also noted gaps in the recording and analysis of ineligible patient requests, eligibility appeals, and the downstream impact of cancelled journeys on patient care, which limited visibility of unmet demand. Felicty confirmed that management had accepted all findings, with extended implementation timescales reflecting the scale, complexity and system wide dependencies involved, and she thanked operational colleagues for their engagement during the audit process.

Members acknowledged the reasonable assurance opinion and recognised the significant operational pressures under which the CMP was being applied. Ceri Jackson highlighted concern regarding the disproportionate impact of repeated journey cancellations on certain patient groups, particularly those with protected characteristics and those living in rural

areas, and emphasised the importance of understanding patient harm and equality impacts.

Members expressed concern that the eligibility criteria for NEPTS had not been reviewed for a prolonged period and noted that this was outside the trust's control. They nevertheless welcomed the audit's focus on improving transparency, recording and analysis of ineligible requests and cancellations, recognising this as a means of strengthening evidence to inform system level discussions. Members also acknowledged the impact of CMP decisions on staff wellbeing and supported the proposed actions, noting that implementation timescales were appropriately cautious given system dependencies and funding constraints.

6.2.4 **Job Evaluation**

Felicity Quance presented the internal audit report on job evaluation, confirming a **reasonable assurance** opinion and noting a clear improvement from the previous audit in 2021, which had concluded limited assurance. Felicity advised that the improved rating reflected increased stability within the job evaluation function, the absence of a backlog of evaluations and stronger execution of core processes.

Felicity confirmed that appropriate national policies and guidance were in place and accessible, with generally compliant arrangements for new posts, re-evaluations and outcome reviews. Felicty highlighted six medium priority findings, relating primarily to gaps in refresher training and training records for job matchers and consistency checkers, weaknesses in documentation and audit trails, instances of potential conflicts of interest and limited reporting of progress against improvement actions to the ELT. Felicty advised that the focus had shifted from addressing fundamental weaknesses to embedding consistency, strengthening assurance evidence and improving oversight.

Members welcomed the reasonable assurance opinion and noted the clear improvement from the previous audit. Carl Kneeshaw advised that progress reflected increased stability within the job evaluation function, additional permanent resource, and the elimination of historic backlogs, while acknowledging that some improvement actions had been delayed due to recent capacity constraints and organisational change. Carl confirmed that agreed actions were realistic and that assurance would continue to be provided through PCC reporting.

Christian Fox welcomed the findings from a staff side perspective, and confirmed that refresher training for job evaluation practitioners was planned for summer and early autumn 2026, which would address gaps identified in training records and support continued improvement in consistency and confidence in the process.

The committee took assurance from the reasonable assurance ratings of the Risk Management and Board Assurance Framework; Welsh Language Standards; Capacity Management Plan (Ambulance Care); and Job Evaluation Internal Audit Reports.

7.1 AUDIT WALES AUDIT COMMITTEE UPDATE APRIL 2026

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

7.1.1 Fflur Jones updated members on Audit Wales activity, advising that work on the 2025/26 accounts is due to commence. Fflur noted that the digital review had been delayed due to internal Audit Wales capacity issues, but would be shared with the trust imminently. Fflur further advised that the review of NEPTS was progressing well and would be reported to the next meeting. The estates review remained in fieldwork stage with reporting anticipated in September. Members were also signposted to recently published Audit Wales reports of wider interest, including reviews on additional learning needs and the regional integration fund, and to Audit Wales' Annual Plan for 2026/27.

7.2 AUDIT WALES DETAILED AUDIT PLAN 2026

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

7.2.1 Yvonne Thomas presented the detailed Audit Wales audit plan for 2026/27, explaining that it sets out how the financial audit would be undertaken. Yvonne advised that materiality remained set at 1% of gross expenditure, with lower thresholds applied to sensitive areas such as the remuneration report and related party disclosures. Yvonne confirmed that no WAST specific audit risks had been identified for the year, with only standard sector risks included. Yvonne outlined the audit timetable, confirming that audit work would commence following receipt of the draft accounts, with the ISA 260 report scheduled for ARAC on 23 June, and final sign off planned for late June. Yvonne also confirmed the agreed audit fee increase in line with the Audit Wales fee scheme.

7.2.2 Chris Turley confirmed that the draft accounts were on track for submission, in line with the Welsh Government timetable, and that preparatory meetings were underway. Chris advised that there were no unexpected issues arising from the audit plan, noting positively that the absence of trust specific risks reflected the smoother audit of last year's accounts when compared to the previous year. Chris confirmed that appropriate governance and liaison arrangements were in place with Audit Wales throughout the audit period.

7.2.3 Trish provided assurance on progress of the annual report, advising that the accountability and performance sections were being finalised alongside the accounts. Trish confirmed that non-executive directors had already received the accountability report and that further drafts would be shared as part of the agreed timetable, confirming that overall reporting remained on track. Chris had also shared with draft Remuneration Report tables with board members.

7.2.4 Fflur advised that Audit Wales' 2025/26 performance audit programme would include structured assessment work, noting that the scope may differ slightly this year and that further detail would be shared once confirmed. Fflur confirmed that local performance audit work would focus on the NHS 111 service, and that the national thematic review on diabetes would not directly involve the trust, allowing greater focus on the 111 review.

7.2.5 The Chair thanked Audit Wales for the update and noted that performance audit reports would primarily be considered by the Finance and Performance Committee. The Chair reiterated earlier comments regarding the sequencing of audit reports and the importance of clarity where reports were reviewed by other committees prior to ARAC. The Chair also noted that the current Auditor General would be responsible for signing the 2025/26 accounts and that the incoming Auditor General would take up post in July, enabling a smooth transition for future audit cycles.

The committee received the Audit Wales Audit Committee Update and the Audit Wales Detailed Audit Plan 2026.

8. REGISTER OF INTERESTS AND GIFTS, HOSPITALITY AND SPONSORSHIP ANY OTHER BUSINESS

The papers for this item is in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

8.1 Trish Mills presented the annual update on the register of interests, advising that board member declarations were published routinely with committee papers and updated as interests changed. Trish confirmed that improvements were being made to the process for decision maker declarations, including earlier collection and clearer escalation arrangements, noting that these registers were updated when changes were proactively notified.

8.2 Trish advised that a trust wide communication was being issued in relation to secondary employment, aligned across counter fraud, people and culture and declarations of interest. In relation to gifts, hospitality and sponsorship, Trish noted that declarations were predominantly hospitality related and that cash gifts, where refusal was not possible, had been redirected to the

trust charity in line with policy. Trish highlighted that the trust benchmarked mid-range compared with other UK ambulance services, and confirmed that ongoing communications would continue, particularly around peak gifting periods.

8.3 Members welcomed the transparency of the registers and the fact that declarations were being made proactively. The Chair queried the definition of "hospitality", noting that many entries appeared to relate to legitimate business activity rather than inducements, and received assurance that appropriate prior approval had been obtained and that acceptance remained proportionate and in line with policy**.**

8.4 Carl Window highlighted the importance of assurance in relation to secondary employment declarations, querying the extent to which compliance could be centrally evidenced and audited. It was noted that current systems limit the ability to provide a single central audit view**,** with responsibility primarily held at local level, although members supported continued strengthening of controls, communication and assurance as system capability develops.

The committee received the Trust Board Register of Interests as at the 31 March 2026; the Trust Decision-Makers Register of Interests as at the 31 March 2026; and the Gifts, Hospitality and Sponsorship Register as at the 31 March 2026.

9. SELF ASSESSMENT AGAINST 2017 CORPORATE GOVERNANCE CODE FOR CENTRAL GOVERNMENT DEPARTMENTS REVIEW

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

9.1 Trish Mills presented the annual self-assessment against the 2017 Corporate Governance Code for Central Government Departments, advising that the review demonstrated continued compliance with the Code. Trish confirmed that there were no material changes or "comply or explain" issues arising this year and that the document had largely been updated to reflect current information. The committee noted that this self-assessment provided assurance to support the disclosures required within the Annual Governance Statement, and no concerns were raised.

The committee reviewed the 2025/26 self-assessment against the Corporate Governance Code for Central Government Departments 2017, ahead of confirming compliance with the Code in the 2025/26 Annual Governance Statement.

10. REVIEW OF GOVERANCE PRACTICE NOTES

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

10.1 Trish Mills presented the review of three governance practice notes, explaining that these notes provide practical interpretation of the standing orders where clarification is required. Trish advised that the notes covered trust seal arrangements, the conduct of public and private board and committee business, and the use of chair's actions. No material changes had been made other than minor updates to reflect current practice.

10.2 The Chair confirmed that the committee was content with the continued use of governance practice notes and agreed that future updates should only be brought back to ARAC where material changes were proposed. The committee endorsed the practice notes as an appropriate and proportionate mechanism for supporting consistent application of the standing orders.

The committee reviewed and approved the edited governance practice notes GPN 001 for the application/use of the Trust Seal; GPN 002 for the treatment of business for private board/committee meetings; and GPN for the treatment of business via Chair's Action.

11. REFLECTIONS

11.1 The Chair reflected positively on the quality of the papers and the depth of discussion, thanking officers, auditors and members for their contributions. Umar Ahmad commented favourably on the effectiveness of the meeting and the quality of debate.

12. ANY OTHER BUSINESS

12.1 No other business was raised.

13. DATE OF THE NEXT MEETING

13.1 23 June 2026 at 9:30am.

MEETING CLOSE: 12:14

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
14.3/02022026	2 March 2026	**Non-Compliance with Standing Orders: Publication of Late Papers**	It was agreed that reporting on late papers would be undertaken on a six monthly basis, with flexibility for earlier reporting on an exception or trend basis should concerns arise.	Trish Mills	3 September 2026	**Update at ARAC 28 April 2026** Trish Mills advised that contrary to the usual annual process, there had been no formal review of Standing Orders by Welsh Government in 2025/26. Trish confirmed this position had been included in the Annual Report and noted that Welsh Government was considering specific areas through Ministerial Advisory Groups, with a review anticipated during the current financial year.	Not due

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

Agenda Item No.	5.1

REPORT TITLE

2025/26 Annual Accounts

MEETING

Name of meeting	Audit, Risk & Assurance Committee
Date of meeting	23 June 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Executive Director of Finance & Corporate Resources
Author(s) of report	Jillian Gill, Int Head of Financial Technical Projects

PURPOSE OF REPORT

☐ Approval	☒ Endorsement
☐ Assurance	☒ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY:

[See writing and presentation guidance here to inform this section]

1. The Trust submitted its unaudited draft Annual Accounts for 2025/26 to the Welsh Government, on 1 May 2026, in line with the agreed timetable.

2. The accounts for the year ended 31 March 2026 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.

3. The draft accounts have been subject to a detailed audit by Audit Wales, as described within this paper, and amended where required.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to:

1. Recommend that the Trust's Annual Accounts for 2025/26 be approved by the Trust Board, at its meeting on 25 June 2026.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

The Committee is requested to receive the following:

Annex 1 Annual Accounts 2025/26

Governance and assurance checks to support decision-making and demonstrate alignment and risk mitigation

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☒ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
n/a

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☐ Safe	☐ Timely	☐ Effective
☒ Efficient	☐ Equitable	☐ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☐ Leadership	☐ Workforce	☐ Culture
☒ Information	☐ Learning Improvement and Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☐ A socially responsible and inclusive employer	☐ An innovative and sustainable organisation	☐ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document here for further details.

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
25 June 2026	Trust Board for approval

SITUATION

1. The Trust submitted its unaudited 2025/26 Draft Accounts on 1 May 2026 to the Welsh Government, in line with the agreed timetable.

BACKGROUND

2. The accounts for the year ended 31 March 2026 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 (**Annex 1**) as presented demonstrate that the Trust has:

   a) As per the draft accounts, continued to report a retained surplus of £0.078 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 2023/24 to 2025/26 as shown below.

Annual financial performance

	2023-24 £000	2024-25 £000	2025-26 £000	**2023-24 to 2025-26 Financial duty £000**
Retained surplus	85	70	78	**233**
Less Donated asset / grant funded revenue adjustment	0	0	0	**0**
Adjusted surplus/ (Deficit)	85	70	78	**233**

c) The NHS Wales Planning Framework for the period 2025-2028 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 2025-2028 in accordance with NHS Wales Planning Framework. This was approved on 30 June 2025;

The Welsh Ambulance Services University NHS Trust has therefore met its statutory duty to have an approved financial plan;

d) The Trust Expended Capital Investment funds of £33.176 million, meeting the target by utilising 100% of the Trust's Welsh Government set Capital Resource Limit; and

e) The Trust achieved Public Sector Payments Policy (PSPP) of 98.4% 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 2025/26 financial statements, citing that they provide a true and fair view of the Trust's finances in the 2025/26 financial year.

8. The audited accounts are due to be presented to Trust Board for their approval on 25th June 2026.

9. The final approved and audited annual accounts and annual report are then due to be submitted to Welsh Government by 30 June 2026 as one single unified document in line with the agreed timetable.

RECOMMENDATION

10. The recommendation(s) are as set out in the front cover above.

Welsh Ambulance Services University NHS Trust

Foreword

These accounts for the period ended 31 March 2026 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 main contact centres, three 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 are 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

Welsh Health Circular WHC/2016/054 replaced WHC/2015/014 'Statutory and Financial Duties of Local Health Boards bnd NHS Trusts' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2025-2026. 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 2026

	Note	2025-26 £000	2024-25 £000
Revenue from patient care activities	3	334,320	314,362
Other operating revenue	4	10,017	9,229
Operating expenses	5.1	(345,312)	(324,956)
Operating (deficit)/surplus		(975)	(1,365)
Investment revenue	6	1,019	1,400
Other gains and losses	7	318	375
Finance costs	8	(284)	(340)
Retained surplus	2.1.1	78	70
Other Comprehensive Income			
Items that will not be reclassified to net operating costs:			
Net gain/(loss) on revaluation of property, plant and equipment		2,364	243
Net gain / (loss) on revaluation of right of use assets		0	0
Net gain/(loss) on revaluation of intangible assets		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Net gain/(loss) on revaluation of PPE and Intangible assets held for sale		0	0
Impairments and reversals		(1,285)	(436)
Movements in other reserves		0	149
Transfers between reserves		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Reserves eliminated on dissolution		0	0
Sub total		1,079	(44)
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		1,079	(44)
Total comprehensive income for the year		1,157	26

The notes on pages 6 to 76 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2026

		Note	31 March 2026	31 March 2025
			£000	£000
Non-current assets	Property, plant and equipment	**13**	**114,988**	100,372
	Right of Use Assets	**13.3**	**8,878**	8,830
	Intangible assets	**14**	**4,011**	3,662
	Trade and other receivables	**17.1**	**16,470**	401
	Other financial assets	**18**	**0**	0
	Total non-current assets		**144,347**	113,265
Current assets	Inventories	**16.1**	**2,308**	2,114
	Trade and other receivables	**17.1**	**15,002**	15,163
	Other financial assets	**18**	**0**	0
	Cash and cash equivalents	**19**	**17,877**	8,036
			35,187	25,313
	Non-current assets held for sale	**13.2**	**0**	0
	Total current assets		**35,187**	25,313
Total assets			**179,534**	138,578
Current liabilities	Trade and other payables	**20**	**(38,987)**	(29,488)
	Borrowings	**21**	**(1,282)**	(1,900)
	Other financial liabilities	**22**	**0**	0
	Provisions	**23**	**(5,619)**	(4,617)
	Total current liabilities		**(45,888)**	(36,005)
Net current assets/(liabilities)			**(10,701)**	(10,692)
Total assets less current liabilities			**133,646**	102,573
Non-current liabilities	Trade and other payables	**20**	**0**	0
	Borrowings	**21**	**(5,215)**	(5,890)
	Other financial liabilities	**22**	**0**	0
	Provisions	**23**	**(24,250)**	(6,580)
	Total non-current liabilities		**(29,465)**	(12,470)
Total assets employed			**104,181**	90,103
Financed by Taxpayers' equity:				
	Public dividend capital		**91,263**	80,343
	Retained earnings		**(1,108)**	(3,294)
	Revaluation reserve		**14,026**	13,054
	Other reserves		**0**	0
	Total taxpayers' equity		**104,181**	90,103

The financial statements were approved by the Board on 25th June 2026 and signed on behalf of the Board by:

Chief Executive: Emma Wood

Date: 25 June 2026

The notes on pages 6 to 76 form part of these accounts.

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

2025-26	Public Dividend Capital £000	Retained earnings £000	Revaluation reserve £000	Total £000
Changes in taxpayers' equity for 2025-26				
Balance as at 31 March 2025	80,343	(3,294)	13,054	90,103
NHS Wales Transfer	0	0	0	0
RoU Asset Transitioning Adjustment	0	2,001	0	2,001
Impact of IFRS 16 on PPP/PFI Liability	0	0	0	0
Balance at 1 April 2025	80,343	(1,293)	13,054	92,104
Retained surplus/(deficit) for the year		78		78
Net gain/(loss) on revaluation of property, plant and equipment		0	2,364	2,364
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 PPE and Intangible 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	(1,285)	(1,285)
Gain/(Loss) on other reserve movements		0	0	0
Transfers between reserves		107	(107)	0
Reclassification adjustment on disposal of available for sale financial assets		0	0	0
Reserves eliminated on dissolution	0	0	0	0
Total in year movement	0	185	972	1,157
New Public Dividend Capital received	10,468			10,468
Public Dividend Capital repaid in year	0			0
Public Dividend Capital extinguished/written off	0			0
PDC Cash Due but not issued	452			452
Other movements in PDC in year	0			0
Balance at 31 March 2026	91,263	(1,108)	14,026	104,181

The notes on pages 6 to 76 form part of these accounts.

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

2024-25 Changes in taxpayers' equity for 2024-25	Public Dividend Capital £000	Retained earnings £000	Revaluation reserve £000	Total £000
Balance at 31 March 2024	79,701	(3,366)	13,100	89,435
NHS Wales Transfer	0	0	0	0
RoU Asset Transitioning Adjustment	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 PPE and Intangible 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)
Net Gain/(loss) on Other Reserve		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	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 CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2026

	Note	2025-26 £000	2024-25 £000
Operating surplus/(deficit)	SOCI	(975)	(1,365)
Movements in working capital	30	(12,464)	58
Other cash flow adjustments	31	39,953	22,436
Provisions utilised		(2,040)	(2,432)
Interest paid		(115)	(173)
Net cash inflow (outflow) from operating activities		24,359	18,524
Cash flows from investing activities			
Interest received		1,019	1,400
(Payments) for property, plant and equipment		(25,569)	(22,779)
Proceeds from disposal of property, plant and equipment		318	375
(Payments) for intangible assets		(276)	(3,836)
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		(24,508)	(24,840)
Net cash inflow (outflow) before financing		(149)	(6,316)
Cash flows from financing activities			
Public Dividend Capital received		10,468	5,199
Public Dividend Capital repaid		0	(4,557)
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		1,774	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		(2,252)	(3,375)
Cash transferred (to)/from other NHS Wales bodies		0	0
Net cash inflow (outflow) from financing activities		9,990	(2,733)
Net increase (decrease) in cash and cash equivalents		9,841	(9,049)
Cash [and] cash equivalents at the beginning of the financial year	19	8,036	17,085
Cash [and] cash equivalents at the end of the financial year	19	17,877	8,036

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 2025-26 Manual for Accounts. The accounting policies contained in that manual follow the 2025-26 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 2025-26. 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 a 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 the 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 the 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, NHS Wales organisation;

● 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. NHS Wales organisations have 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 the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation 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 the NHS organisation; 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 there from 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.

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 the 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

The NHS Trust will not apply IFRS 16 to any new leases of intangible assets applying the treatment described in section 1.7 instead.

List any other expedients employed by the entity (such as low value 5(b) or 15 on componentisation HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

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 2025-26. 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 the 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 -Not UK endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

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 2025-26 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			**2023-24 to 2025-26 Financial duty**
	2023-24 £000	2024-25 £000	2025-26 £000	**£000**
Retained surplus	85	70	78	**233**
Less Donated asset / grant funded revenue	0	0	0	**0**
Adjusted surplus/ (Deficit)	85	70	78	**233**

The Welsh Ambulance Services University NHS Trust has met its financial duty to break even over the 3 years 2023-24 to 2025-26.

2.1.2 Integrated Medium Term Plan (IMTP)

The NHS Wales Planning Framework for the period 2025-2028 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 2025-2028 in accordance with NHS Wales Planning Framework.

The Minister for Health and Social Services approval status.

Status	**Approved**
Date	30/06/2025

The Welsh Ambulance Services University NHS Trust has therefore met its statutory duty to have an approved financial plan.

2. Financial Performance (cont)

2.2.1. Capital Resource Limit

Capital Resource Limit	31 March 2026 £000
Gross capital expenditure	33,176
Less: Disposals	0
Less: Donated and Government granted additions	0
Less: Peppercorn leased capital additions	0
Charge against Capital Resource Limit	33,176
Capital Resource Limit	**33,176**
(Over) / Underspend against Capital Resource Allocation	0

The Trust has met the target.

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:

	2025-26	2024-25
Total number of non-NHS bills paid	**51,020**	**53,595**
Total number of non-NHS bills paid within target	**50,221**	**52,380**
Percentage of non-NHS bills paid within target	**98.4%**	**97.7%**

The Trust has met the target.

3. Revenue from patient care activities	2025-26	2024-25
	£000	£000
Local health boards	5,887	5,966
NHSW Joint Commissioning Committee	292,707	275,426
Welsh NHS Trusts	969	899
Welsh Special Health Authorities	0	0
Foundation Trusts	0	0
Other NHS England bodies	168	97
Other NHS Bodies	0	0
Local Authorities	9	1
Welsh Government	34,167	31,546
Welsh Government - Hosted Bodies	0	0
Non NHS:		
Private patient income	0	0
Overseas patients (non-reciprocal)	0	0
Injury Costs Recovery (ICR) Scheme	182	183
Other revenue from activities	231	244
Total	**334,320**	314,362

Injury Cost Recovery (ICR) Scheme income:

	2025-26	2024-25
	%	%
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	24.62	24.45

4. Other operating revenue	2025-26	2024-25
	£000	£000
Income generation	0	0
Patient transport services	0	0
Education, training and research	2,289	2,000
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	241	336
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	89	67
Business unit	0	0
Scheme Pays Reimbursement Notional	0	0
Other	7,398	6,826
Total	**10,017**	9,229
Total Patient Care and Operating Revenue	**344,337**	**323,591**

Other revenue comprises:		
Personal injury benefit scheme (PIBS)	55	738
Hazardous Area Response Team (HART)	2,917	2,773
Other minor services income	2,077	1,597
Funding for impairments (as funds flow monies)	2,300	1,718
Income from asset sales to staff	49	
Total	**7,398**	6,826

5. Operating expenses	**2025-26**	2024-25
5.1 Operating expenses	**£000**	£000
Local Health Boards	**117**	142
Welsh NHS Trusts	**1,191**	1,068
Welsh Special Health Authorities	**0**	0
Goods and services from other NHS bodies	**0**	0
Goods and services from NHSW JCC	**0**	0
Local Authorities	**0**	0
Purchase of healthcare from non-NHS bodies	**13,323**	13,012
Welsh Government	**674**	612
Other NHS Trusts	**0**	0
Directors' costs	**2,074**	1,984
Operational Staff costs	**256,563**	234,153
Single lead employer Staff Trainee Cost	**0**	0
Collaborative Bank Staff Cost	**0**	0
Supplies and services - clinical	**4,813**	5,383
Supplies and services - general	**2,384**	3,014
Consultancy Services	**715**	584
Establishment	**5,106**	5,328
Transport	**17,410**	17,179
Premises	**16,538**	16,691
Impairments and Reversals of Receivables	**0**	0
Depreciation	**15,072**	14,854
Depreciation (RoU Asset)	**2,576**	3,409
Amortisation	**1,066**	1,137
Impairments and reversals of property, plant and equipment	**2,301**	1,653
Fixed asset impairments and reversals (RoU Assets)	**0**	0
Impairments and reversals of intangible assets	**0**	65
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Audit fees	**215**	202
Other auditors' remuneration	**91**	0
Losses, special payments and irrecoverable debts	**719**	1,665
Research and development	**0**	0
Expense related to short-term leases	**83**	101
Expense related to low-value asset leases (excluding short-term leases)	**0**	0
Other operating expenses	**2,281**	2,720
Total	**345,312**	324,956

5. Operating expenses (continued)

5.2 Losses, special payments and irrecoverable debts:

Charges to operating expenses **Increase/(decrease) in provision for future payments:**	**2025-26** **£000**	2024-25 £000
Clinical negligence;-		
Secondary care	**18,303**	(36)
Primary care	**0**	0
Redress Secondary Care	**(48)**	0
Redress Primary Care	**0**	0
Personal injury	**96**	767
All other losses and special payments	**400**	485
Defence legal fees and other administrative costs	**210**	64
Structured Settlements Welsh Risk Pool	**0**	0
Gross increase/(decrease) in provision for future payments	**18,961**	1,280
Contribution to Welsh Risk Pool	**0**	0
Premium for other insurance arrangements	**0**	0
Irrecoverable debts	**(28)**	60
Less: income received/ due from Welsh Risk Pool	**(18,214)**	325
Total charge	**719**	1,665

Personal injury includes £0.065m in respect of permanent injury benefits.

The contribution to the Welsh Risk Pool risk share is disclosed within Note 5.1.

	2025-26 **£**	2024-25 £
Permanent injury included within personal injury:	**65,214**	727,208

6. Investment revenue	2025-26	2024-25
Rental revenue :	**£000**	£000
PFI/MIM finance lease revenue:		
Planned	**0**	0
Contingent	**0**	0
Other finance lease revenue	**0**	0
Interest revenue:		
Bank accounts	**1,019**	1,400
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Total	**1,019**	1,400

7. Other gains and losses	2025-26	2024-25
	£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	**318**	375
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	**318**	375

8. Finance costs	2025-26	2024-25
	£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	**115**	173
Interest on obligations under PFI/MIM contracts:		
Main finance cost	**0**	0
Contingent finance cost	**0**	0
Impact of IFRS 16 on PPP/PFI/ MIM contracts	**0**	0
Interest on late payment of commercial debt	**0**	0
Other interest expense	**0**	0
Total interest expense	**115**	173
Provisions unwinding of discount	**169**	167
Periodical Payment Order unwinding of discount	**0**	0
Other finance costs	**0**	0
Total	**284**	**340**

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.

The periods in which the remaining agreements will expire are shown below:

	2025-26 Low Value & Short Term	2025-26 Other	2025-26 Total	2024-25 Total
Payments recognised as an expense				
	£000	**£000**	**£000**	£000
Minimum lease payments	**83**	**1,190**	**1,273**	1,355
Contingent rents	**0**	**0**	**0**	0
Sub-lease payments	**0**	**0**	**0**	0
Total	**83**	**1,190**	**1,273**	1,355

Total future minimum lease payments	**2025-26**	**2025-26**	**2025-26**	2024-25
Payable:	**£000**	**£000**	**£000**	£000
Not later than one year	**0**	**965**	**965**	853
Between one and five years	**0**	**1,152**	**1,152**	1,233
After 5 years	**0**	**237**	**237**	284
Total	**0**	**2,354**	**2,354**	2,370
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

Main sources of receipts are -
-The Trust leases part of Vantage Point House to Aneurin Bevan NHS Trust in respect of their GP Out of Hours service.
- The Trust recharges out a variable service charge to North Wales Fire Service who reside at the AFSRC site based in Wrexham.

Rental Revenue

Receipts recognised as income	**2025-26**	2024-25
	£000	£000
Rent	**0**	0
Contingent rent	**0**	0
Other	**245**	244
Total rental revenue	**245**	244

Total future minimum lease payments	**2025-26**	2024-25
Receivable:	**£000**	£000
Not later than one year	**245**	244
Between one and five years	**0**	0
After 5 years	**1**	1
Total	**246**	245

10. Employee costs and numbers

10.1 Employee costs Operational Staff	Permanently employed staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Other Staff	2025-26 £000	2024-25 £000
	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	193,429	146	957	0	0	194,532	181,506
Social security costs	24,167	0	0	0	0	24,167	17,852
Employer contributions to NHS Pensions Scheme	39,905	0	0	0	0	39,905	36,878
Other pension costs	66	0	0	0	0	66	108
Other post-employment benefits	0	0	0	0	0	0	0
Termination benefits	330	0	0	0	0	330	164
Total	**257,897**	**146**	**957**	**0**	**0**	**259,000**	236,508

Of the total above:		
Charged to capital	354	336
Charged to revenue	258,646	236,172
Total	**259,000**	236,508

Net movement in accrued employee benefits (untaken staff leave)	148	82

10.2 Average number of employees	Permanently Employed	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Other Staff	2025-26 Total	2024-25 Total
	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	746	4	10	0	0	760	690
Medical and dental	1	0	0	0	0	1	1
Nursing, midwifery registered	219	0	0	0	0	219	196
Professional, scientific and technical staff	2	0	0	0	0	2	3
Additional Clinical Services	1,957	0	0	0	0	1,957	1,974
Allied Health Professions	1,199	0	0	0	0	1,199	1,162
Healthcare scientists	0	0	0	0	0	0	0
Estates and Ancillary	68	0	2	0	0	70	65
Students	0	0	0	0	0	0	0
Total	**4,192**	**4**	**12**	**0**	**0**	**4,208**	4,091

10.3. Retirements due to ill-health	2025-26	2024-25
Number	5	3
Estimated additional pension costs £	462,360	289,507

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. These additional pension costs have been calculated on an average basis and will be 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

Exit packages cost band (including any special payment element)	2025-26 Number of compulsory redundancies Whole numbers only	2025-26 Number of other departures Whole numbers only	2025-26 Total number of exit packages Whole numbers only	2025-26 Number of departures where special payments have been made Whole numbers only	2024-25 Total number of exit packages Whole numbers only
less than £10,000	0	2	2	1	0
£10,000 to £25,000	0	1	1	0	3
£25,000 to £50,000	0	2	2	0	1
£50,000 to £100,000	0	2	2	0	1
£100,000 to £150,000	0	1	1	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	8	8	1	5

Exit packages cost band (including any special payment element)	2025-26 Cost of compulsory redundancies £	2025-26 Cost of other departures £	2025-26 Total cost of exit packages £	2025-26 Cost of special element included in exit packages £	2024-25 Total cost of exit packages £
less than £10,000	0	8,209	8,209	7,000	0
£10,000 to £25,000	0	10,360	10,360	0	55,000
£25,000 to £50,000	0	65,506	65,506	0	30,000
£50,000 to £100,000	0	137,607	137,607	0	79,365
£100,000 to £150,000	0	108,654	108,654	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	330,336	330,336	7,000	164,365

Total Exit Costs Paid in Year	Total paid in year 2025-26 £	Total paid in year 2024-25 £
Exit costs paid in year	88,040	53,648
Total	88,040	53,648

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	2025-26 Agreements Number	2025-26 Total value of agreements £
Type of other departures		
Voluntary redundancies including early retirement contractual costs	6	322,127
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**	1	7,000
Other please specify	1	1,209
Total	**8**	**330,336**

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 amount shown above includes one non-contractual severance payments of £7000.
Included within 'Other' above is one contractual payment of £1209 relating to annual leave.

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 their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's

Total Pay and benefits			**£'000**			**£'000**
Chief Executive Total pay and benefits range			**190-195**			**185-190**
Highest paid Director Total pay and benefits range			**190-195**			**185-190**

	2025-26	**2025-26**	**2025-26**	2024-25	2024-25	2024-25
	£	**£**		£	£	
Total pay and benefits mid-point	**Chief Executive**	**Employee**	**Ratio**	Chief Executive	Employee	Ratio
25th percentile pay ratio	**192,500**	**31,371**	**6.14:1**	187,500	30,420	6.16:1
Median pay	**192,500**	**41,644**	**4.62:1**	187,500	38,999	4.81:1
75th percentile pay ratio	**192,500**	**53,828**	**3.58:1**	187,500	53,416	3.51:1
Salary component of total pay and benefits						
25th percentile pay ratio	**192,500**	**26,999**		187,500	26,060	
Median pay	**192,500**	**33,992**		187,500	30,420	
75th percentile pay ratio	**192,500**	**47,280**		187,500	45,637	

Total pay and benefits mid-point	**Highest Paid Director**	**Employee**	**Ratio**	Highest Paid Director	Employee	Ratio
25th percentile pay ratio	**192,500**	**31,371**	**6.14:1**	187,500	30,420	6.16:1
Median pay	**192,500**	**41,644**	**4.62:1**	187,500	38,999	4.81:1
75th percentile pay ratio	**192,500**	**53,828**	**3.58:1**	187,500	53,416	3.51:1
Salary component of total pay and benefits						
25th percentile pay ratio	**192,500**	**26,999**		187,500	26,060	
Median pay	**192,500**	**33,992**		187,500	30,420	
75th percentile pay ratio	**192,500**	**47,280**		187,500	45,637	

In 2025-26, 0 (2024-25, 0) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £23,875 to £192,500 (2024-25, £23,970 to £187,500).

The all staff range includes directors with the exception of the highest paid CEO Director as appropriate and excludes the non-executive directors 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 2025/26 are the 3.6% pay increase for employees covered by Agenda for Change (AfC) and the 3.25% pay increase for employees covered by Executive and Senior Posts (ESP).

10.6.2 Percentage Changes

	2024-25 to 2025-26	2023-24 to 2024-25
% Change from previous financial year in respect of Chief Executive	**%**	%
Salary and allowances	**2.7**	8.7
Performance pay and bonuses	**0.0**	0.0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	**2.7**	8.7
Performance pay and bonuses	**0.0**	0.0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	**2.2**	7.8
Performance pay and bonuses	**0.0**	0.0

2023/24 figures were provided in accordance with the guidance at the time, however this did not take into account the 2024/25 Manual for Accounts guidance, which was applied in 2024/25 only.

As per the Manual for Accounts, 2025/26 has reverted to the methodology used in 2023/24, whereby the amounts included are following salary sacrifice deductions.

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 2024/25 guidance.

The 2.7% reported in 2025/26 is the result of a new Chief Executive and the pay award received.

In terms of the average pay per FTE, the 7.8% reported in 2024/25 relates to the agreed pay increases across the organisation, with salary sacrifice schemes excluded as per the 2024/25 guidance.

The 2.2% reported in 2025/26 is the result of the pay award received.

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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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 2025-26 tax year (2024-25 £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.

	2025-26 Number	**2025-26 £000**	2024-25 Number	2024-25 £000
NHS				
Total bills paid in year	**1,245**	**10,783**	1,580	13,122
Total bills paid within target	**1,183**	**10,343**	1,547	12,774
Percentage of bills paid within target	**95.0%**	**95.9%**	97.9%	97.3%
Non-NHS				
Total bills paid in year	**51,020**	**90,984**	53,595	142,878
Total bills paid within target	**50,221**	**89,869**	52,380	141,256
Percentage of bills paid within target	**98.4%**	**98.8%**	97.7%	98.9%
Total				
Total bills paid in year	**52,265**	**101,767**	55,175	156,000
Total bills paid within target	**51,404**	**100,212**	53,927	154,030
Percentage of bills paid within target	**98.4%**	**98.5%**	97.7%	98.7%

12.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2025-26 £	2024-25 £
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 :

2025-26	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
At 1 April 2025	9,125	31,891	0	18,391	18,877	87,921	15,261	1,025	182,491
Indexation	288	2,370	0	0	0	0	0	0	2,658
Additions - purchased	0	1,297	0	22,773	936	4,029	1,761	115	30,911
Additions - donated	0	0	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0	0	0
Additions - Initial recognition of MIMs funded as	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	1,280	0	(19,179)	2,280	14,649	855	115	0
Revaluation	0	(1,286)	0	0	0	0	0	0	(1,286)
Reversal of impairments	0	1,145	0	0	0	0	0	0	1,145
Impairments	0	(3,518)	0	0	0	(66)	0	0	(3,584)
Reclassified as held for sale	0	0	0	0	(934)	(10,843)	0	0	(11,777)
Disposals other than by sale	0	0	0	0	(198)	(381)	(806)	(132)	(1,517)
At 31 March 2026	9,413	33,179	0	21,985	20,961	95,309	17,071	1,123	199,041
Depreciation									
At 1 April 2025	0	3,701	0	0	13,479	56,490	7,669	780	82,119
Indexation	0	294	0	0	0	0	0	0	294
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	(138)	0	0	0	0	0	0	(138)
Reclassified as held for sale	0	0	0	0	(934)	(10,843)	0	0	(11,777)
Disposals other than by sale	0	0	0	0	(198)	(381)	(806)	(132)	(1,517)
Charged during the year	0	1,006	0	0	1,702	10,107	2,189	68	15,072
At 31 March 2026	0	4,863	0	0	14,049	55,373	9,052	716	84,053
Net book value									
At 1 April 2025	9,125	28,190	0	18,391	5,398	31,431	7,592	245	100,372
Net book value									
At 31 March 2026	9,413	28,316	0	21,985	6,912	39,936	8,019	407	114,988
Net book value at 31 March 2026 comprises :									
Purchased	9,413	28,316	0	21,985	6,904	39,889	8,019	407	114,933
Donated	0	0	0	0	8	47	0	0	55
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2026	9,413	28,316	0	21,985	6,912	39,936	8,019	407	114,988
Asset Financing:									
Owned	9,413	28,316	0	21,985	6,912	39,936	8,019	407	114,988
On-SoFP MIMS Funded PPP contracts	0	0	0	0	0	0	0	0	0
On-SoFP PPP/PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual interest	0	0	0	0	0	0	0	0	0
At 31 March 2026	9,413	28,316	0	21,985	6,912	39,936	8,019	407	114,988

The net book value of land, buildings and dwellings at 31 March 2026 comprises :

	£000
Freehold	35,300
Long Leasehold	2,429
Short Leasehold	0
Total	37,729

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 :

2024-25	Land	Buildings, excluding dwellings	Dwellings	Assets under construttion 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
Additions - Initial recognition of MIMs funded ass	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 PPP/PFI contracts	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.

13. Property, plant and equipment :

Disclosures:

i) Donated Assets
Welsh Ambulance Services 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.

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
£2.234m was received from Welsh Government in respect of compensation for assets impaired during the year. This includes £1.684m in respect of two buildings which were brought into use during the financial year. The compensation received is included within the income statement.

v) Write Downs
There has been accelerated depreciation of £0.122m during the year.

vi)Open Market Value
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.

Gain/(Loss) on Sale

Asset description	Reason for sale	Gain/(Loss) on sale £000
Vehicles	No longer serviceable	**180**
Equipment	No longer serviceable	**138**
		318

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 2025	**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	0	0	0	0	0	0
Balance c/f 31 March 2026	**0**	**0**	**0**	**0**	**0**	**0**
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	0	0	0	0	0	0
Balance c/f 31 March 2025	0	0	0	0	0	0

Within Note 13 there is cost and accumulated depreciation of £10.843m for Transport and £0.934m for Plant & Machinery reclassified as held for sale during the year. These relate to fully depreciated vehicles and equipment, of which £11.016m have been sold during the year and £2.511m remain within assets held for sale as they did not sell during the year.

Note 7 shows the gain on disposal made during the year from the sale of these assets.

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, one is significant in its own right:

- VPH HQ & Control held under land and buildings NBV at 31 March 2026 £1.897m

Included within the Additions line below is the dilapidations asset value of £1.774m

2025-26	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2025	**0**	**11,822**	**0**	**0**	**0**	**130**	**25,733**	**0**	**37,685**
Additions	7	2,543	0	0	0	0	(80)	0	2,470
Transfer from/into other NHS bodies	0	276	0	0	0	0	0	0	276
Disposals other than by sale	0	(933)	0	0	0	0	(2,640)	0	(3,573)
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 2026	**7**	**13,708**	**0**	**0**	**0**	**130**	**23,013**	**0**	**36,858**
Depreciation at 1 April 2025	**0**	**3,995**	**0**	**0**	**0**	**34**	**24,826**	**0**	**28,855**
Recognition	0	0	0	0	0	0	0	0	0
Transfers from/into other NHS bodies	0	122	0	0	0	0	0	0	122
Disposals other than by sale	0	(933)	0	0	0	0	(2,640)	0	(3,573)
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	1,704	0	0	0	45	827	0	2,576
At 31 March 2026	**0**	**4,888**	**0**	**0**	**0**	**79**	**23,013**	**0**	**27,980**
Net book value at 1 April 2025	**0**	**7,827**	**0**	**0**	**0**	**96**	**907**	**0**	**8,830**
Net book value at 31 March 2026	**7**	**8,820**	**0**	**0**	**0**	**51**	**0**	**0**	**8,878**

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	809	0	0	0	0	0	0	809
NHS Wales Market Value Leases	0	244	0	0	0	0	0	0	244
Other Public Sector Peppercorn Leases	7	323	0	0	0	0	0	0	330
Other Public Sector Market Value Leases	0	1,410	0	0	0	0	0	0	1,410
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	0
Private Sector Market Value Leases	0	6,034	0	0	0	51	0	0	6,085
Total	7	8,820	0	0	0	51	0	0	8,878

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 one is significant in its own right:

- VPH HQ & Control held under land and buildings NBV at 31 March 2025 £2,214k.

2024-25	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
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**

13.3 Right of Use Assets continued
Quantitative disclosures

Maturity analysis	2025-26 LAND	2025-26 BUILDINGS	2025-26 OTHER	2025-26 TOTAL	2024-25 Total
Contractual undiscounted cash flows relating to lease liabilities	**£000**	**£000**	**£000**	**£000**	**£000**
Less than 1 year	0	1,344	42	**1,386**	1,988
2-5 years	0	4,142	14	**4,156**	4,353
> 5 years	0	1,324	0	**1,324**	1,745
Less finance charges allocated to future periods	0	(367)	(2)	**(369)**	(296)
Total	**0**	**6,443**	**54**	**6,497**	**7,790**

Lease Liabilities (net of irrecoverable VAT)	**£000**	**£000**
Current	**1,282**	1,900
Non-Current	**5,215**	5,890
Total	**6,497**	**7,790**

Amounts Recognised in Statement of Comprehensive Net Expenditure	**£000**	**£000**
Depreciation	**2,576**	3,409
Impairment	**0**	0
Variable lease payments not included in lease liabilities - Interest expense	**115**	173
Sub-leasing income	**0**	0
Expense related to short-term leases	**83**	101
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	**(115)**	(173)
Repayments of principal on leases	**(2,252)**	(3,375)
Total	**(2,367)**	**(3,548)**

The nature of the Trust's leasing activities relates mostly properties used as operational sites, stations and office accommodation. The Airwave lease ceased in June 2025. Vehicles are also leased mainly as pool cars.

The Trust is committed to leases which have not yet commenced at Bangor Workshops and Dolgellau.

14. Intangible assets

2025-26	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 2025	8,834	0	2,536	0	0	388	11,758
Revaluation		0			0	0	0
Reclassifications	107	0	0	0	0	(107)	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions							
- purchased	300	0	622	0	0	493	1,415
- 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	(2,073)	0	(1,092)	0	0	0	(3,165)
At 31 March 2026	7,168	0	2,066	0	0	774	10,008
Amortisation							
At 1 April 2025	6,457	0	1,639	0	0	0	8,096
Revaluation		0			0	0	0
Reclassifications	0	0	0	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	724	0	342	0	0	0	1,066
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	(2,073)	0	(1,092)	0	0	0	(3,165)
Accumulated amortisation at 31 March 2026	5,108	0	889	0	0	0	5,997
Net book value At 1 April 2025	2,377	0	897	0	0	388	3,662
Net book value At 31 March 2026	2,060	0	1,177	0	0	774	4,011
Net book value							
Purchased	2,060	0	1,177	0	0	774	4,011
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 2026	2,060	0	1,177	0	0	774	4,011

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

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 Lives (UEL) 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.

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

Impairments in the period arose from:	2025-26 Property, plant & equipment £000	2025-26 Right of Use Assets £000	2025-26 Intangible assets £000	2025-26 Held for sale assets £000	2025-26 Financial Assets £000	2025-26 Total Asset Impairment £000
Loss or damage from normal operations	66	0	0	0	0	**66**
Abandonment of assets in the course of construction	0	0	0	0	0	**0**
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	0	0	0	0	0	**0**
Other	4,665	0	0	0	0	**4,665**
Reversal of impairment	(1,145)	0	0	0	0	**(1,145)**
Total of all impairments	**3,586**	**0**	**0**	**0**	**0**	**3,586**
Analysis of impairments :						
Impairments charged to the Statement of Comprehensive Net Expenditure	2,235	0	0	0	0	2,235
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	1,285	0	0	0	0	1,285
Impairments as a result of a loss of economic value or service potential charged to Statement of Comprehensive Net Expenditure	66	0	0	0	0	66
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	**3,586**	**0**	**0**	**0**	**0**	**3,586**

Impairments in the period arose from:	2024-25 Property, plant & equipment £000	2024-25 Right of Use Assets £000	2024-25 Intangible assets £000	2024-25 Held for sale assets £000	2024-25 Financial Assets £000	2024-25 Total Asset Impairment £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

Included within the above total of £3.587m are the following items:-

- £1.684m relates to the capital spend on building works to leased assets which were deemed by the District Valuer to require impairment, this was charged to operating expenses.

- £0.066m was impaired for vehicles written off, 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 £2.982m was required as there were instances where the value of the buildings had not been enhanced. Of this amount, £1.696m was charged to operating expenses and £1.286m was charged to the Revaluation Reserve.

- £1.145m of impairments previously charged to operating expenses were reversed following upward indexation of assets.

16. Inventories

16.1 Inventories

	31 March 2026 £000	31 March 2025 £000
Drugs	157	131
Consumables	1,834	1,728
Energy	0	0
Work in progress	0	0
Other	317	255
Total	**2,308**	2,114
Of which held at net realisable value:	0	0

16.2 Inventories recognised in expenses

	31 March 2026 £000	31 March 2025 £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 2026	31 March 2025
Current	**£000**	£000
Welsh Government	**2,490**	564
NHSW Joint Commissioning Committee	**797**	48
Welsh Health Boards	**844**	1,834
Welsh NHS Trusts	**159**	180
Welsh Special Health Authorities	**85**	16
Non - Welsh Trusts	**103**	61
Other NHS	**19**	29
2019-20 Scheme Pays - Welsh Government Reimbursement	**0**	0
Welsh Risk Pool Claim reimbursement:-		
NHS Wales Secondary Health Sector	**4,325**	5,815
NHS Wales Primary Sector FLS Reimbursement	**0**	0
NHS Wales Redress	**129**	297
Other	**0**	0
Local Authorities	**51**	73
Other receivables	**3,581**	2,540
Provision for impairment of trade receivables	**(205)**	(273)
Pension Prepayments		
NHS Pensions Agency	**0**	0
NEST	**0**	0
Other prepayments	**2,624**	3,979
Accrued income	**0**	0
Right of Use capital receivables	**0**	0
Capital Receivables		
Tangibles capital receivables	**0**	0
Intangibles capital receivables	**0**	0
Other capital prepayments	**0**	0
Sub-total	**15,002**	15,163
Non-current		
Welsh Government	**0**	0
NHSW Joint Commissioning Committee	**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	**16,074**	0
NHS Wales Primary Sector FLS Reimbursement	**0**	0
NHS Wales Redress	**0**	0
Other	**0**	0
Local Authorities	**0**	0
Other receivables	**396**	401
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
Right of Use capital receivables	**0**	0
Capital Receivables		
Tangibles capital receivables	**0**	0
Intangibles capital receivables	**0**	0
Other capital prepayments	**0**	0
Sub-total	**16,470**	401
Total trade and other receivables	**31,472**	15,564

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 £0.250m (£0.823m in 2024-25).

17.2 Receivables past their due date but not impaired

	31 March 2026	31 March 2025
	£000	£000
By up to 3 months	105	478
By 3 to 6 months	23	346
By more than 6 months	122	0
Balance at end of financial year	**250**	824

17.3 Expected Credit Losses (ECL) Allowance for bad and doubtful debts

	31 March 2026	31 March 2025
	£000	£000
Balance at 1 April	(273)	(260)
Transfer to other NHS Wales body	0	0
Provision utilised (Amount written off during the year)	12	23
Provision written back during the year no longer required	0	0
(Increase)/Decrease in provision during year	56	(36)
ECL/Bad debts recovered during year	0	0
Balance at end of financial year	**(205)**	(273)

17.4 Receivables VAT

	31 March 2026	31 March 2025
	£000	£000
Trade receivables	28	33
Other	0	0
Total	**28**	**33**

18. Other financial assets

	31 March 2026 £000	31 March 2025 £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 at amortised cost	0	0
Derivatives	0	0
Other (Specify)		
Held to maturity investments at amortised costs	0	0
At fair value through SOCI	0	0
Available for sale at FV	0	0
Capital Financial Assets		
Loans at amortised cost	0	0
Right of Use Asset Finance Sublease	0	0
Total	**0**	**0**

	31 March 2026 £000	31 March 2025 £000
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 at amortised cost	0	0
Derivatives	0	0
Other (Specify)		
Held to maturity investments at amortised costs	0	0
At fair value through SOCI	0	0
Available for sale at FV	0	0
Capital Financial Assets		
Loans at amortised cost	0	0
Right of Use Asset Finance Sublease	0	0
Total	**0**	**0**

RoU Sub-leasing income Recognised in Statement of Comprehensive Net Expenditure	**2025-26**	**2024-25**
RoU Sub-leasing income	0	**0**

19. Cash and cash equivalents

	31 March 2026	31 March 2025
	£000	£000
Opening Balance	**8,036**	17,085
Net change in year	**9,841**	(9,049)
Closing Balance	**17,877**	8,036
Made up of:		
Cash with Government Banking Service (GBS)	**17,773**	7,992
Cash with Commercial banks	**104**	44
Cash in hand	**0**	0
Total cash	**17,877**	8,036
Current investments	**0**	0
Cash and cash equivalents as in SoFP	**17,877**	8,036
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash & cash equivalents as in Statement of Cash Flows	**17,877**	8,036

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are;

Lease Liabilities (ROUA) £2.252m
Lease Liabilities (short-term and low value leases) £0.083m

The movement relates to cash, no comparative information is required by IAS 7 in 2025-26.

20. Trade and other payables at the SoFP Date	31 March 2026	31 March 2025
Current	**£000**	£000
Welsh Government	**2,028**	7
NHSW Joint Commissioning Committee	**0**	319
Welsh Health Boards	**364**	351
Welsh NHS Trusts	**550**	463
Welsh Special Health Authorities	**0**	3
Other NHS	**55**	0
Taxation and social security payable / refunds:		
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	139
Other taxes payable to HMRC	**2,526**	2,174
National Insurance contributions payable to HMRC	**2,870**	2,226
Non-NHS trade payables - revenue	**6,567**	7,232
Local Authorities	**38**	47
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
Pensions: staff	**3,344**	3,100
Non NHS Accruals	**8,586**	7,675
Deferred Income:		
Deferred income brought forward	**176**	310
Deferred income additions	**227**	168
Transfer to/from current/non current deferred income	**0**	0
Released to the Income Statement	**(176)**	(302)
Other liabilities - all other payables	**0**	0
Payments on account	**0**	0
Impact of IFRS 16 on SoFP PFI contracts	**0**	0
Right of Use asset payables	**20**	245
Capital asset payables		
Tangibles - Payables	**10,571**	5,229
Intangibles - Payables	**1,241**	102
Obligations under finance leases, HP contracts	**0**	0
Imputed finance lease element of on SoFP PFI contracts	**0**	0
PFI assets – deferred credits	**0**	0
Capital Payments on account	**0**	0
Sub-total	**38,987**	29,488

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, £3.329m relates to the NHS Pension scheme (£3.083m 2024/25) and £0.015m to the NEST pension scheme (£0.017m 2024/25).

20. Trade and other payables at the SoFP Date (cont)

	31 March 2026	31 March 2025
Non-current	**£000**	£000
Welsh Government	**0**	0
NHSW Joint Commissioning Committee	**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
Overdraft	**0**	0
Rentals due under operating leases	**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
Payments on account	**0**	0
Impact of IFRS 16 on SoFP PFI contracts	**0**	0
Right of Use asset payables	**0**	0
Capital asset payables		
Capital Creditors - Tangibles	**0**	0
Capital Creditors - Intangibles	**0**	0
Obligations under finance leases, HP contracts	**0**	0
Imputed finance lease element of on SoFP PFI contracts	**0**	0
PFI assets – deferred credits	**0**	0
Capital Payments on account	**0**	0
Sub-total	**0**	**0**
Total	**38,987**	29,488

20. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled as follows:	**31 March 2026**	31 March 2025
	£000	£000
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

21. Borrowings Current	31 March 2026 £000	31 March 2025 £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
Other service concession arrangement liabilities:		
Main liability	0	0
Lifecycle replacement received in advance	0	0
Other	0	0
RoU Lease Liability	1,282	1,900
Capital Borrowings	0	0
PFI liabilities:		
Main liability	0	0
Lifecycle replacement received in advance	0	0
Finance lease liabilities	0	0
Total	**1,282**	1,900
Non-current		
Bank overdraft - GBS	0	0
Bank overdraft - Commercial bank	0	0
Loans from:		
Welsh Government	0	0
Other entities	0	0
Other service concession arrangement liabilities:		
Main liability	0	0
Lifecycle replacement received in advance	0	0
Other	0	0
RoU Lease Liability	5,215	5,890
Capital Borrowings	0	0
PFI liabilities:		
Main liability	0	0
Lifecycle replacement received in advance	0	0
Finance lease liabilities	0	0
Total	**5,215**	5,890

21.2 Loan advance/strategic assistance funding

Amounts falling due:	31 March 2026 £000	31 March 2025 £000
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 2026	31 March 2025
Current	**£000**	£000
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 2026	31 March 2025
Non-current	**£000**	£000
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

2025-26

Current	At 1 April 2025	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 2026
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-										
Secondary Care	1,758	0	(207)	0	0	2,431	(559)	(113)	0	3,310
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	201	0	29	0	0	100	(57)	(148)	0	125
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	1,474	0	0	(50)	0	924	(884)	(577)	168	1,055
All other losses and special payments	0	0	0	0	0	400	(400)	0	0	0
Defence legal fees and other administration	330	0	0	0	0	253	(86)	(215)	0	282
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	0	0	7	(15)	(1)	1	8
2019-20 Scheme Pays - Reimbursement	0		0	13	0	0	(9)	(3)	0	1
Restructurings	0		0	0	0	0	0	0		0
Other	838		0	0	0	0	0	0		838
Capital provisions										
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Total	4,617	0	(178)	(37)	0	4,115	(2,010)	(1,057)	169	5,619
Non Current										
Clinical negligence:-										
Secondary Care	0	0	0	0	0	15,985	0	0	0	15,985
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	6,489	0	0	50	0	191	(17)	(442)	0	6,271
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	15	0	0	0	0	173	(13)	(1)	0	174
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	41		0	0	0	0	0	(17)	0	24
2019-20 Scheme Pays - Reimbursement	35		0	(13)	0	0	0	0	0	22
Restructurings	0		0	0	0	0	0	0		0
Other	0		0	0	0	0	0	0		0
Capital provisions										
RoU Asset Dilapidations CAME	0		0	0	0	1,774	0	0		1,774
Other Capital Provisions	0		0	0	0	0	0	0		0
Total	6,580	0	0	37	0	18,123	(30)	(460)	0	24,250
TOTAL										
Clinical negligence:-										
Secondary Care	1,758	0	(207)	0	0	18,416	(559)	(113)	0	19,295
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	201	0	29	0	0	100	(57)	(148)	0	125
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	7,963	0	0	0	0	1,115	(901)	(1,019)	168	7,326
All other losses and special payments	0	0	0	0	0	400	(400)	0	0	0
Defence legal fees and other administration	345	0	0	0	0	426	(99)	(216)	0	456
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	57		0	0	0	7	(15)	(18)	1	32
2019-20 Scheme Pays - Reimbursement	35		0	0	0	0	(9)	(3)	0	23
Restructurings	0		0	0	0	0	0	0		0
Other	838		0	0	0	0	0	0		838
Capital provisions										
RoU Asset Dilapidations CAME	0		0	0	0	1,774	0	0		1,774
Other Capital Provisions	0		0	0	0	0	0	0		0
Total	11,197	0	(178)	0	0	22,238	(2,040)	(1,517)	169	29,869

Expected timing of cash flows:

	In year to 31 March 2027	Between 01-Apr-27 to 31 March 2031	Thereafter	Totals
	£000	£000	£000	£000
Clinical negligence:-				
Secondary Care	3,310	15,985	0	19,295
Primary Care	0	0	0	0
Redress Secondary Care	125	0	0	125
Redress Primary Care	0	0	0	0
Personal injury	1,055	2,101	4,170	7,326
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	282	174	0	456
Structured Settlements - WRPS	0	0	0	0
Pensions - former directors	0	0	0	0
Pensions - other staff	8	24	0	32
2019-20 Scheme Pays - Reimbursement	1	5	17	23
Restructuring	0	0	0	0
Other	838	0	0	838
Capital provisions				
RoU Asset Dilapidations CAME	0	934	840	1,774
Other Capital Provisions	0	0	0	0
Total	5,619	19,223	5,027	29,869

"Other" provisions of £0.838m is in relation to the dilapidation of leasehold premises (not covered under IFRS16).

23. Provisions (continued)

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
Current										
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
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
Other	838		0	0	0	0	0	0		838
Capital provisions										
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
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
Other	0		0	0	0	0	0	0		0
Capital provisions										
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	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
Other	838		0	0	0	0	0	0		838
Capital provisions										
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Total	12,311	0	(137)	0	0	2,907	(2,432)	(1,619)	167	11,197

24 Contingencies

24.1 Contingent liabilities

Provision has not been made in these accounts for the following amounts:	31 March 2026 £000	31 March 2025 £000
Legal claims for alleged medical or employer negligence;		
Secondary care	11,161	11,298
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	363	291
Other	0	0
Total value of disputed claims	**11,524**	11,589
Less amounts recoverable in the event of claims being successful	**(10,331)**	(10,338)
Net contingent liability	**1,193**	1,251

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 2026 £000	31 March 2025 £000
Guarantees	0	0
Indemnities	0	0
Letters of comfort	0	0
Total	**0**	0

24.3 Contingent assets

	31 March 2026 £000	31 March 2025 £000
None	0	0
	0	0
	0	0
	0	**0**

The Trust has no contingent assets.

25. Capital commitments and Other Service Concession Arrangements

25.1 Capital commitments

Future commitments under capital expenditure contracts not already disclosed as liabilities in the accounts at the statement of financial position sheet date :

	31 March 2026	31 March 2025
	£000	£000
Property, plant and equipment	**6,076**	2,682
Right of Use Assets	**0**	0
Intangible assets	**309**	0
Total	**6,385**	2,682

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 2026	
	No. of cases	**£**
Clinical negligence:-		
Secondary Care	16	664,266
Primary Care	0	0
Redress Secondary Care	22	65,653
Redress Primary Care	0	0
Personal injury	61	773,604
All other losses and special payments	167	400,005
Total	**266**	**1,903,528**

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:			
Clinical negligence	21RT4MN0009	401,660	401,660

	Number of cases	**£**	**£**
Sub-total	**1**	**401,660**	**401,660**
All other cases paid in year	265	1,501,868	11,359,464
Total cases paid in year	**266**	**1,903,528**	**11,761,124**

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	86	1,216,837
Cumulative amount greater than £300k	2	1,606,395
Total	**88**	**2,823,232**

27. Right of Use / Finance leases obligations

27.1 Obligations (as lessee)

Amounts payable under right of use asset leases:

2025-26

	LAND	BUILDINGS	OTHER	TOTAL
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
Minimum lease payments	£000	£000	£000	£000
Within one year	0	1,344	42	**1,386**
Between one and five years	0	4,142	14	**4,156**
After five years	0	1,324	0	**1,324**
Less finance charges allocated to future periods	0	(367)	(2)	**(369)**
Minimum lease payments	**0**	**6,443**	**54**	**6,497**
Included in:				
Current borrowings	0	1,242	40	**1,282**
Non-current borrowings	0	5,201	14	**5,215**
	0	**6,443**	**54**	**6,497**
Present value of minimum lease payments				
Within one year	0	1,242	40	**1,282**
Between one and five years	0	3,941	14	**3,955**
After five years	0	1,260	0	**1,260**
Present value of minimum lease payments	**0**	**6,443**	**54**	**6,497**
Included in:				
Current borrowings	0	1,242	40	**1,282**
Non-current borrowings	0	5,201	14	**5,215**
	0	**6,443**	**54**	**6,497**

A contract was entered into with Airwave during 2007/08 in respect of the National Ambulance Radio Re-procurement Project. This contract was extended a number of times over the years due to the national replacement scheme being delayed. It finally ended in June 2025. This is included within 'Other'.

2024-25	LAND	BUILDINGS	OTHER	TOTAL
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
Minimum lease payments	£000	£000	£000	£000
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**

27.2 Right of Use Assets receivables (as lessor)

The Trust did not hold any Right of Use Assets lease receivables, as a lessor, at the balance sheet date.

Amounts receivable under right of use assets:

		31 March 2026	31 March 2025
Gross investment in leases		**£000**	£000
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 is committed to leases which have not yet commenced at Bangor Workshops and Dolgellau.

28 Private Finance Initiatives (PFI) / Public Private Partnerships (PPP)

The Trust has no PFI/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 2026	31 March 2025
	£000	£000
(Increase) / decrease in inventories	(194)	5
(Increase) / decrease in trade and other receivables - non-current	(16,069)	(13)
(Increase) / decrease in trade and other receivables - current	161	2,112
Increase / (decrease) in trade and other payables - non-current	(675)	(2,007)
Increase / (decrease) in trade and other payables - current	8,881	(9,542)
Total	(7,896)	(9,445)
Adjustment for accrual movements in fixed assets - creditors	(6,481)	6,166
Adjustment for accrual movements in fixed assets - debtors	0	0
Adjustment for accrual movements in right of use assets - creditors	1,518	3,331
Adjustment for accrual movements in right of use assets - debtors	0	0
Other adjustments	395	6
Total	(12,464)	58

Included within 'Other' above is PDC due from the Welsh Government of £0.452m

31. Other cash flow adjustments

Other cash flow adjustments	31 March 2026 £000	31 March 2025 £000
Depreciation	17,648	18,263
Amortisation	1,066	1,137
(Gains)/Loss on Disposal	0	0
Impairments and reversals	2,301	1,718
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	18,938	1,318
Total	39,953	22,436

32. Events after reporting period

During April 2026 a new level of board fees was shared with all Welsh NHS CEOs. The decision to increase remuneration rates relates to a wider review of the underlying Welsh Government Remuneration Scheme guidance, the scheme used to ensure the level of fees paid to public office holders (not just those in the Welsh NHS) is transparent and applied consistently. Updates on the review have been a regular topic discussed at CEO and Chair level forums hosted by the Welsh Government.

Agreement to increase the level of fees was made by the Cabinet Secretary for Finance and Welsh Language on 1 December. This was noted by CSHSC on 2 December.
The correspondence to the CEOs confirmed that it had been agreed. The Welsh Government Remuneration Scheme daily rates should increase from the 1 January 2026, a change relating to the 2025-26 pay cycle.

As Ministerial approval was made to implement the change on 1 December 2025 the 2025-26 payment falls within the category of an adjusting post balance sheet event. The value of this was £1780.

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 25th June 2026; the financial statements were then certified by the by the Auditor General for Wales on 26th June 2026.

33. Related Party Transactions

The Welsh Government is regarded as a related party. During the year the Trust has 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	3,170	25,638	2,028	2,038
JCC	0	292,742	0	797
Aneurin Bevan University Health Board	387	691	166	287
Betsi Cadwaladr University Health Board	400	2,055	84	215
Cardiff & Vale University Health Board	85	290	25	85
Cwm Taf Morgannwg University Health Board	108	947	30	146
Hywel Dda University Health Board	116	1,530	25	22
Powys Teaching Health Board	84	100	4	37
Swansea Bay University Health Board	99	659	29	51
Public Health Wales NHS Trust	48	177	0	3
Velindre University NHS Trust	2,228	1,329	549	156
Health Education and Improvement Wales (HEIW)	14	1,024	0	37
Digital Health & Care Wales (DHCW)	1,614	186	0	47
Welsh Local Authorities	2,565	246	38	51
	10,918	**327,614**	**2,978**	**3,972**

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 (2024/25 £0.010m) with no other transactions being made. Net assets of the Charity amount to £0.701m.

The Welsh Government income shown above includes £2.3m relating to impairment funding, and excludes PDC of £10.920m.

Jason Killens, former Chief Executive (until 18/07/2025), is a Member of the Order St John, Honorary Professor at Swansea University and Chairperson /Company Director of the Association of Ambulance Chief Executives (AACE).

Lee Brooks, Executive Director of Operations, 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 Unversity 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 2025-26 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	92	16	0	0
St John Ambulance	2,466	0	0	0
Swansea University	54	5	0	0
TOTAL	**2,612**	**21**	**0**	**0**

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

37.1. 9.4% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1 April 2025 to 31 March 2026. This has been calculated from actual Welsh Government expenditure for the 9.4% staff employer pension contributions between April 2025 and February 2026 alongside Trust data for March 2026.

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:

	2025-26	2024-25
STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2026	**£000**	**£000**
Revenue from patient care activities	15,776	14,577
Operating expenses	15,776	14,577
3. Analysis of gross operating costs		
3. Revenue from patient care activities		
Welsh Government	15,776	14,577
Welsh Government - Hosted Bodies	0	0
4. Other Operating Revenue		
Other	0	0
5.1 Operating expenses		
Directors' costs	121	115
Staff costs	15,655	14,462

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 2025	0
Liability for remaining payments @ 31 March 2026	0
	0
Arising during year	0
Utiised	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)

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

Agenda Item No.	05.2

REPORT TITLE

Trust Annual Report 2025/26

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	23 June 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/ Board Secretary
Author(s) of report	Trish Mills, Director of Corporate Governance/ Board Secretary Alex Payne, Corporate Governance Manager

PURPOSE OF REPORT

☐ Approval	☒ Endorsement
☐ Assurance	☐ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY:

[See writing and presentation guidance here to inform this section]

1. The Trust submitted its draft Annual Report 2025/26 on 8 May 2026 to Audit Wales and Welsh Government in line with the agreed timetable as prescribed by the final 2025/26 Manual for Accounts.

2. Comments from both Audit Wales and Welsh Government have been incorporated into the final report, which is attached for review and endorsement by the Audit, Risk and Assurance Committee (ARAC).

3. The Annual Report includes the Performance Report and the Accountability Report. Both have been developed in accordance with the NHS Wales 2025/26 Manual for Accounts**.**

4. The Accountability Report includes the Statement of Directors' responsibilities in respect of the Accounts (page 102) which will be signed by order of the board by the Chair, Chief Executive and Executive Director of Finance and Corporate Resources.

5. 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.

6. The draft annual report with the draft remuneration table was circulated to the Trust Board members for comment before submission to Welsh Government and Audit Wales on the 8 May 2026. Comments received from Audit Wales and Welsh Government did not require material amendment.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Audit, Risk and Assurance Committee is requested to:

1. To **endorse** the Annual Report 2025/26 and recommend its approval by the Trust Board.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room
The Audit, Risk and Assurance Committee is requested to receive the following: **Annex 1** Annual Report 2025/26

Governance and assurance checks to support decision-making and demonstrate alignment and risk mitigation

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☒ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
n/a

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☒ Equitable	☒ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☒ Workforce	☒ Culture
☒ Information	☒ Learning Improvement and Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document here for further details.

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
15 April 2026	Email circulation of Accountability Report to Chair, Vice-Chair and Chair of the Audit, Risk and Assurance Committee
15 April 2026	Email circulation of the Accountability Report to the Executive Leadership Team
24 April 2026	Email circulation of the remuneration tables to the non-executive directors
8 May 2026	Email circulation of the full Annual Report to the board, following draft submission to Audit Wales and Welsh Government
11 June 2026	Email circulation of the full annual report to the Executive Leadership Team

SITUATION

1. The Trust submitted its draft Annual Report 2025/26 on 8 May 2026 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 report which is attached for review and endorsement by the Audit, Risk and Assurance Committee.

BACKGROUND

2. The annual report, which consists of Part 1 - Performance Report and Part 2 – Accountability Report, have been prepared in accordance with the NHS Wales 2025/26 Manual for Accounts Chapter 3.

ASSESSMENT

3. Following submission of the draft report to Audit Wales and Welsh Government on 8 May 2026 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.

4. The Trust's Annual Report is part of a suite of documents that provides information about the Trust. In accordance with the NHS Wales 2025/26 Manual for Accounts and HM Treasury's Financial Reporting Manual, the Annual Report for 2025/26 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 2025/26, the Trust has prepared a report for the 2025/26 which was approved by the board on 28 May 2026.

   - **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.

5. The Accountability Report includes the Statement of Directors' responsibilities in respect of the Accounts (page 102) 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 156-57) has been reviewed by Remuneration Committee members and the Executive Leadership Team.

6. 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 30 July 2026. 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.

7. The Welsh Government Manual for Accounts 2025/26 requires the Trust to submit as a single PDF document of the two-part report and the financial accounts. For this submission, the document attached will be entitled Annual Report and Financial Accounts 2025/26 and include the financial accounts as 'Part 3'. This is required to be submitted to Welsh Government by 30 June 2026.

RECOMMENDATION

8. The recommendation(s) are as set out in the front cover above.

NEXT STEPS

9. Prepare the final annual report and accounts 2025/26 documents for submission to the meeting of the meeting of the Trust Board on the 25 June 2026, for approval. Any adjustments requested by the ARAC will be incorporated.

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

Welsh Ambulance Services University NHS Trust

Annual Report and Accounts 2025/26

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 2025/26.

In accordance with the NHS Wales 2025/26 Manual for Accounts and HM Treasury's Financial Reporting Manual, our Annual Report for 2025/26 includes:

Part 1: Performance Report that 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 that 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, staff and remuneration.

Part 3: Financial Statements that detail how the Trust has spent its money and met its obligations. These account for the period ended 31 March 2026 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.

A separate Duty of Quality Report for 2025/26 is prepared and the disclosures required in line with the duty of candour reporting are included in this report. Duty of candour is reported regularly to the Quality, Patient Experience and Safety Committee and in the Putting Things Right Reports. This will be included in the publications page of Trust's website in due course.

A separate Welsh Language Standards Annual Report is prepared, encompassing the Trust's compliance with the Welsh Langue Standards and the Welsh Government's More Than Just Words Action Plan. This will be included in the publications page of the Trust's website in due course.

Whilst acronyms are explained in full when they are first used, a glossary is included at Appendix 3 to Part 2 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 2025/26 Annual Report will be available on the Trust's Publications page in due course.

WELCOME MESSAGE FROM THE CHAIR AND CHIEF EXECUTIVE OFFICER

Welcome to the Welsh Ambulance Services University NHS Trust Annual Report for 2025/26. This report brings together more information about our performance, the way we make decisions and how we have managed our resources to deliver the best possible services for the people of Wales.

It is no secret that the emergency and urgent care system, along with much of the NHS across the UK, remains under sustained pressure. However, throughout the year, we have started to see some green shoots of improvement, both within our own organisation and across the wider NHS Wales.

This has also been a seminal year for us in terms of changes to the way Welsh Government measures our performance, and the way we deliver care to our patients. The introduction of the Welsh Government's Ambulance Performance Framework has meant a clearer focus on patient outcomes, while our clinical model transformation has seen us investing in clinical triage to ensure receive the right care for their needs.

Nearly 60% of 999 calls now receive a remote clinical assessment, significantly reducing unnecessary conveyance to hospital and improving patient experience. Our NHS 111 service continues to play a critical role as a national front door to urgent care, supported by ongoing digital innovation. At the same time, we recognise that performance challenges remain, particularly during periods of peak demand, and further improvement is required.

We are grateful to our colleagues across the wider NHS in Wales, where we have seen some important improvements in handover delays, which has improved safety for patients and made for a better experience for our crews. We continue to work with health boards across Wales to support our collective ambition to minimise delays in handing over patients at hospital, and this work will continue to be a focus in 2026/27.

For our Non-Emergency Patient Transport Services, rising demand and increasing complexity have impacted reliability and patient experience this year, something we are actively addressing, working with our commissioners and Welsh Government, and which will remain a priority for the year ahead.

Of course, as well as our focus on clinical care, we need to ensure that we have the right financial stewardship and governance arrangements in place to Our Accountability Report demonstrates the strength of our governance arrangements. The Board has maintained clear oversight of quality, performance, finance and risk, supported by a mature system of internal control. We continue to value the insights provided by Audit Wales and internal audit, which recognise effective leadership and sound governance while supporting continuous improvement. Transparency, learning and accountability remain central to our approach as a public service organisation.

Despite significant operational pressures, the Trust has maintained financial stability during 2025/26, delivering a small surplus and meeting its statutory financial duties. This has been achieved through disciplined financial management and delivery of efficiency savings, while continuing to invest in priority areas including workforce, digital capability, fleet and infrastructure. Our capital programme has supported improvements to our estate and our contribution to the decarbonisation agenda.

We are aware that maintaining a financially balanced organisation is challenging in the current climate and we remain committed to working with partners, commissioners and Welsh Government to ensure we continue to deliver the best value within the funding envelope that we can.

Our staff and volunteers are central to everything we do. We have continued to invest in their wellbeing, development and leadership, recognising the impact that ongoing operational pressures can have on individuals and teams. While progress has been made in strengthening our organisational culture and engagement, we know there is more to do. Supporting our people, reducing absence, and ensuring a positive and inclusive working environment will remain central to our workforce agenda.

As we look to 2026/27, our priorities are clear. We will continue to embed our clinical model, strengthen partnerships across the health and care system, and focus on those actions that will have the greatest impact on patient safety, experience and outcomes.

We recognise that many of the challenges we face are systemic and cannot be addressed in isolation. We remain committed to working closely with Welsh Government, commissioners, health boards and our wider partners to deliver sustainable improvements for the people of Wales.

Finally, we want to thank our staff, volunteers, partners and the communities we serve. Your support, resilience and commitment continue to make a real difference.

With our very best wishes,

Colin Dennis

Chair of the Trust Board



Emma Wood

Chief Executive Officer



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PART 1: PERFORMANCE REPORT

PERFORMANCE OVERVIEW

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 2025 to 31 March 2026. The Performance Report is produced in line with the requirements of the NHS Wales 2025/26 Manual for Accounts.

Statement from the Chief Executive Officer

Our patients and our people continue to access and work in a health care system which experiences periods of high pressure in hospitals and our communities, with resultant avoidable patient harm and moral injury for our staff. At the March 2026 Trust Board, a patient harm assessment report identified the following overall assessments for the three patient pathways at WAST:

- NHS 111 pathway: potential harm assessed as low, although delays in access to clinical advice may increase exposure to deterioration for a small number of patients
- 999 / Emergency Medical Service pathway: potential harm assessed as medium, primarily driven by sustained system delay and ambulance availability constraints associated with hospital handover delays
- Non-Emergency Patient Transport Service: Potential harm assessed as medium, reflecting operational pressures including short-notice bookings and system cancellations

Levels of patient harm have started to reduce because of actions taken by the Trust and its partners. In 2024 the Trust embarked on a sector leading clinical transformation programme, with the aim of clinically assessing and treating more patients in the remote space and in our communities and targeting the dispatch of physical emergency assets to those patients most in need, who will need conveying to emergency departments. This transformation has been supported by partners, with Welsh Government putting in place the new Ambulance Performance Framework (APF), which the Trust implemented in 2025/26.

Welsh Government has also increased attention on releasing emergency ambulance capacity, requiring health boards to meet the ambulance handover 45 target i.e. a maximum of 45 minutes for an emergency ambulance patient to be handed over at hospitals.

There are positive signs, with reduced patient cancellations, an improving ROSC (return of spontaneous circulation) rate, the highest consult & close rate the Trust has achieved, reduced handover lost hours, largely stable 111 call answering performance and good renal and oncology performance.

The performance overview and the delivery and performance analysis sections of this annual report provide more details. But much remains to be done for the Trust and its partners to deliver the levels of patient safety that we want for the communities we serve. To this end, the Trust has consolidated its 2026-29 Integrated Medium-Term Plan, to free up capacity to support those actions that will have the biggest impact on patients and staff. Particular areas of focus include the 111 digital front end, realising the benefits from the clinical model transformation and increasing the number of completed patient journeys for outpatient appointments.

The Trust continues to work closely with colleagues in Welsh Government and the Joint Commissioning Committee (JCC) on a range of strategic issues and will continue to do so into 2026/27 and beyond. Of note is continued support for, and monitoring of, the ambulance handover 45 initiative, as well as the strategic review of services by the JCC and Health Inspectorate Wales' desktop review which commenced in January 2026.

Finally, I want to reiterate my thanks to all staff and volunteers, blue light partners, commissioners, the private sector and the voluntary sector for their continued support.

[insert signature]

Emma Wood
Chief Executive Officer

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 999 Emergency Medical Services (EMS): including call taking, remote clinical consultation, see and treat and if necessary, conveyance to an appropriate hospital or treating facility
- Non-Emergency Patient Transport Service (also referred to as Ambulance Care): 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 appointment.

The Trust is a commissioned service for EMS, NHS 111 Wales and Ambulance Care via the NHS Wales Joint Commissioning Committee (JCC). The JCC is a joint committee of the seven health boards.

Our purpose and long-term strategy

The WAST purpose statement is '*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 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 the clinical services model to ensure that patients receive the right advice and care, in the right place, every time. The Trust's has accelerated its ambition during 2025/26 to evolve from a traditional ambulance and transport service. It has moved 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. Our long-term strategy will undergo review and refresh during 2026/27.



Summary of 2025/26 Performance

The Trust plays a critical role in supporting the health and wellbeing of the population of Wales by delivering urgent and emergency care services on a national basis. As the sole provider of ambulance services in Wales, the Trust operates at scale across a complex and pressurised healthcare system, responding to life-threatening emergencies, providing clinical advice and triage, supporting planned care through patient transport services, and working closely with partners across health and social care.

This Performance Overview provides a comprehensive narrative account of delivery and performance during 2025/26, setting out the context in which services were delivered, the progress made during the year, and the challenges that continue to require concerted system action.

Throughout 2025/26 the Trust operated within an exceptionally challenging environment. Demand for urgent and emergency care remained consistently high, capacity within acute hospitals was constrained, delayed discharges continued to affect patient flow, and workforce pressures across NHS Wales persisted. These factors combined to place sustained pressure on ambulance services and the wider urgent care system. Despite this, the Trust maintained operational resilience, continued to provide safe care to hundreds of thousands of patients, and progressed significant transformation of its clinical and operational model in line with national policy and strategic ambition.

The year was one of transition and change. The phased introduction of the Welsh Government Ambulance Performance Framework represented a fundamental shift away from the historic reliance on response time targets as the primary indicator of performance. Instead, the framework emphasises clinical harm, patient experience and outcomes, requiring ambulance services and system partners to consider performance through a more patient-centred and clinically meaningful lens. This shift shaped how performance was managed, discussed and assured throughout the year and required a significant cultural change across the Trust and the wider system.

In parallel with this change in the performance framework, the Trust continued to embed its long-term ambition to operate as a clinically led, out-of-hospital urgent and emergency care service. This ambition is central to national policy direction and to the Trust's own strategy, supporting people to receive the right care, in the right place, at the right time. By strengthening clinical assessment, expanding pathways of care and working more closely with community services, the Trust aims to reduce the need for a physical response, reduce avoidable conveyance to hospital, improve patient experience and support a more sustainable urgent care system.

The operating context during 2025/26 cannot be overstated. Rising demand for urgent and emergency care, combined with constraints in hospital capacity and workforce shortages across health and social care, created sustained system pressure. These pressures were reflected in increased ambulance delays, prolonged waits for some patients, and challenges across both emergency and non-emergency services. Similar patterns were observed across health systems in the United Kingdom and beyond, highlighting the systemic nature of these challenges.

Winter planning for 2025/26 focused on demand and capacity modelling, workforce resilience, clinical prioritisation and system flow. Key risks were identified, including sustained service demand, hospital handover delays and workforce pressures, with defined mitigating actions such as strengthened escalation arrangements, enhanced clinical triage, improved coordination through system control centres and targeted investment in additional capacity. The introduction of phase 2 of the ambulance performance framework in 2025/26 was a key mitigation. Despite this context, the Trust maintained organisational stability and robust governance throughout the year. Leadership continuity was sustained following the appointment of a new Chief Executive Officer in October 2025, and the board continued to exercise clear oversight of quality, performance, finance and risk. The Trust remained at routine escalation throughout the year, reflecting its ability to manage pressures within agreed governance arrangements. Financial balance was maintained, and Audit Wales provided positive assurance through its Structured Assessment, recognising effective leadership, strong governance and sound financial management.

A significant development during the year was the introduction of a refreshed patient harm assessment at board level. Implemented in March 2026, this framework enables the Trust to assess performance through a patient safety lens, focusing explicitly on the potential for harm across its core service areas rather than relying solely on proxy indicators such as response times or activity volumes. This approach supports better prioritisation, clearer assurance and more meaningful conversations with system partners about risk and mitigation.

For NHS 111 Wales, potential patient harm was assessed as low. The majority of contacts received through the service relate to lower-acuity conditions, and clinical prioritisation processes are designed to identify and escalate higher-risk presentations. The principal area of risk relates to delays in receiving clinical callbacks during periods of peak demand, particularly at weekends and during seasonal surges. Mitigations include prioritised clinical queues, continuous review of staffing and rostering patterns, enhanced digital access routes and ongoing engagement with commissioners regarding sustainable future capacity.

Emergency Medical Services were assessed as presenting a medium risk of patient harm. This reflects the ongoing impact of ambulance delays associated with hospital handover pressures and prolonged waits for lower-acuity patients in the community. Importantly, the harm assessment also demonstrated evidence of improvement during the year, particularly as hospital handover performance began to recover and ambulance availability increased.

Reducing harm associated with ambulance delays and delayed community response remains a principal organisational priority and is subject to regular board and committee scrutiny.

Non-Emergency Patient Transport Services were also assessed as presenting a medium level of potential harm. This judgement recognised the increasing complexity of demand, extended journey times, and the impact of short-notice cancellations on patient experience.

The Trust has continued to work closely with commissioners and system partners to mitigate these risks, improve reliability and equity of access, and strengthen communication with patients who rely on these services to attend planned and specialist care.

Emergency Medical Services remain the most visible and resource-intensive element of the Trust's delivery model. During 2025/26, the Trust received approximately 549,000 emergency calls, equating to around 420,000 incidents. While overall incident volumes reduced slightly compared with the previous year, demand remained high and continued to exceed available capacity at peak times. This reflected both sustained system pressure and the gradual release of previously unmet demand as hospital handover performance began to improve.

999 call answering performance remained consistently strong throughout the year. Median call answering times remained at approximately one second, with limited variation during periods of increased demand. The Trust retained its Centre of Excellence accreditation for emergency medical dispatch, providing independent assurance regarding the quality, safety and consistency of call handling, triage and control room decision-making.

From July 2025, Emergency Medical Services began operating within the Clinical Model Transformation Programme through Phase One of the Welsh Government Ambulance Performance Framework. This introduced new categories for the most life-threatening emergencies, including Purple Arrest and Red Emergency, and shifted performance monitoring towards clinical outcomes. For Purple Arrest incidents, which include patients in cardiac or respiratory arrest, response performance remained clinically effective.

The Trust has maintained a focus on improving outcomes across the chain of survival, including early recognition, bystander cardiopulmonary resuscitation, defibrillation and advanced life support. Improvements in Return of Spontaneous Circulation (ROSC) rates began to emerge over the second half of 2025. However, this represents the early direction of travel within a longer-term improvement trajectory, with sustained gains expected to be gradual and subject to ongoing variation given the relatively small numbers involved.

Performance for Red Emergency calls was more variable. Response times were affected by ambulance availability, travelling distances and wider system congestion. While national performance expectations were not consistently met, analysis demonstrated that improvements in hospital handover performance and increasing workforce capacity were starting to support recovery. Lower-acuity emergency demand continued to account for the majority of incidents, and during peak winter months some patients experienced extended waits in the community. The Trust has been transparent about these risks and continues to manage delayed community response as a principal organisational risk.

Hospital handover delays continued to exert a significant influence on ambulance availability and patient experience during 2025/26. For much of the year, a substantial proportion of ambulance hours were lost while crews waited outside emergency departments to transfer care. The Welsh Government's ambulance handover 45 programme represented a critical system-wide intervention, supported by updated national handover guidance and an explicit focus on the harm associated with ambulance delays.

Over the course of the year, handover performance showed sustained improvement. Lost ambulance hours reduced, the number of extremely long delays fell, and system understanding of ambulance-related harm increased. While handovers exceeding 45 minutes continued to occur, particularly during periods of peak pressure, the overall trend was positive. Importantly, improved handover performance translated into increased ambulance availability, enabling the Trust to respond to patients who had previously experienced prolonged waits in the community and addressing previously unmet demand.

Clinical model transformation remained a defining feature of performance improvement during the year. The expansion of remote clinical assessment within control rooms enabled a growing proportion of patients to receive timely advice, referral or alternative care without the need for ambulance dispatch. By the end of 2025/26, nearly 60% of all 999 calls received a remote clinical assessment, compared with approximately 30% the previous year, representing a substantial shift in how urgent care is delivered.

Consult and close rates also reached their highest level to date. This reflected improved clinical confidence, enhanced decision-support pathways and a more skilled and experienced clinical workforce. Advanced Paramedic Practitioners and Clinical Navigators played a central role in this improvement, supporting early assessment and directing patients to appropriate community and primary care pathways where clinically safe to do so. This approach reduces unnecessary conveyance, improves patient experience and helps preserve emergency capacity for those most in need.

The Trust continued to expand targeted clinical pathways during 2025/26, focusing on conditions that are among the most common drivers of emergency demand. Falls and respiratory pathways were further developed, supporting earlier intervention, improved clinical outcomes and reduced reliance on emergency department attendance. Community Welfare Responders provided additional support for patients with low-level clinical and social needs, particularly vulnerable individuals and those experiencing environmental or welfare concerns. The majority of patients supported through this model were able to remain safely at home, reducing avoidable conveyance and pressure on emergency departments and urgent care services.

Advanced Paramedic Practitioners were further embedded within Single Points of Access across health boards, strengthening multidisciplinary decision-making and improving alignment between ambulance services, community teams and primary care. While variation in pathway availability and maturity remains across Wales, progress during the year demonstrated the value of closer integration and shared ownership of urgent care demand.

NHS 111 Wales continued to play an increasingly central role in the urgent and emergency care system. For many members of the public, NHS 111 represents the first point of contact when advice or support is required, and the service provides essential clinical triage, navigation and reassurance at scale. During 2025/26, NHS 111 Wales handled over one million telephone calls and supported more than five million interactions via its digital channels.

Telephony demand remained high throughout the year, particularly during evenings, weekends and seasonal surges. The Trust continued to experience challenges in relation to call abandonment and callback waiting times, driven primarily by a mismatch between commissioned staffing levels and peak demand patterns.

Independent modelling confirmed these pressures. While performance against historic benchmarks was not consistently achieved, clinical prioritisation ensured that the most urgent cases received timely assessment and intervention.

A comprehensive re-rostering exercise was undertaken to better align staffing with demand, and the Trust continued to engage with commissioners on the need for sustainable long-term solutions. Productivity improvements among clinical staff helped to mitigate some pressures, and ongoing work focused on reducing avoidable demand and improving access to digital services.

Digital development remained a key priority for NHS 111 Wales. The service's website supported millions of interactions during the year, and the introduction of an artificial intelligence-enabled virtual assistant (Albot) improved access to information and guidance for users.

Work progressed to replace the legacy online symptom checker with a modern solution capable of safer prioritisation and improved integration with telephony services. While further investment is required to fully realise the digital ambition, progress during 2025/26 demonstrated the value of digital innovation in supporting access and system flow.

Non-Emergency Patient Transport Services (NEPTS) play an essential role in supporting patients to access planned and specialist care, including renal dialysis, oncology treatment, outpatient appointments and hospital discharges. During 2025/26, demand for patient transport services continued to rise, driven by demographic change, centralisation of services and increasing patient acuity.

The complexity of NEPTS journeys increased significantly. A growing proportion of patients required stretcher transport, journey distances increased, and appointment schedules became more constrained, reducing operational flexibility. As a result, average journey times increased and available capacity became increasingly stretched. While life-preserving and time-critical journeys, such as renal dialysis and oncology treatment, were prioritised and largely protected, the Trust was unable to meet all eligible demand.

Short-notice cancellations and delays had a detrimental impact on patient experience and were reflected in increased complaint volumes. The Trust acknowledged these issues openly and worked closely with commissioners throughout the year to identify and pursue mitigation options. Areas of focus included demand forecasting, eligibility criteria, commissioning assumptions, patient communication and the exploration of alternative transport solutions. Improving the reliability and experience of NEPTS remains a priority for 2026/27 and we will pursue productivity within existing resource whilst remaining as agile as we can to changing health services across Wales.

Partnership working remained central to delivery across all service areas. The Trust worked collaboratively with Welsh Government, health boards, commissioners, local authorities and third-sector organisations to support urgent and community care reform. Initiatives such as Single Points of Access, Same Day Emergency Care, falls pathways and respiratory services demonstrated the benefits of shared ownership and integrated working, even where variation in implementation remains.

Workforce challenges persisted throughout 2025/26, particularly across frontline clinical services. Recruitment, retention and wellbeing remained key organisational priorities. Targeted actions were taken to strengthen recruitment pipelines, expand training capacity and support staff resilience. The Trust also continued to invest in leadership development and organisational culture, recognising that a supported, skilled and engaged workforce is fundamental to delivering safe and effective care.

Emergency preparedness and business continuity arrangements were reviewed and strengthened, informed by national learning and internal assurance work. The Trust continued to invest in organisational resilience, ensuring that it is equipped to respond effectively to both day-to-day operational pressures and major incidents.

In conclusion, 2025/26 was a year of sustained challenge and meaningful progress for the Welsh Ambulance Services University NHS Trust. Operating within an exceptionally pressurised healthcare system, the Trust continued to deliver essential services to hundreds of thousands of patients while advancing significant clinical and organisational transformation.

While pressures remain evident, particularly where delivery is dependent on wider system flow, the direction of travel is clear. Improvements in hospital handover performance, expanded use of remote clinical assessment, strengthened community pathways and maturing partnerships contributed to reduced patient harm and improved patient experience. The Trust enters 2026/27 with clearer priorities, a strengthened Integrated Medium-Term Plan and growing confidence in its clinical model.

Through continued transparency, collaboration and an unwavering focus on patient safety, the Trust is well positioned to build on the progress made and continue its journey towards delivering high-quality, clinically led urgent and emergency care for the people of Wales.

DELIVERY AND PERFORMANCE ANALYSIS

This section provides commentary on the Trust's key performance measures and a more detailed integrated performance analysis of the Trust's service delivery.

DELIVERING AN EFFECTIVE SERVICE

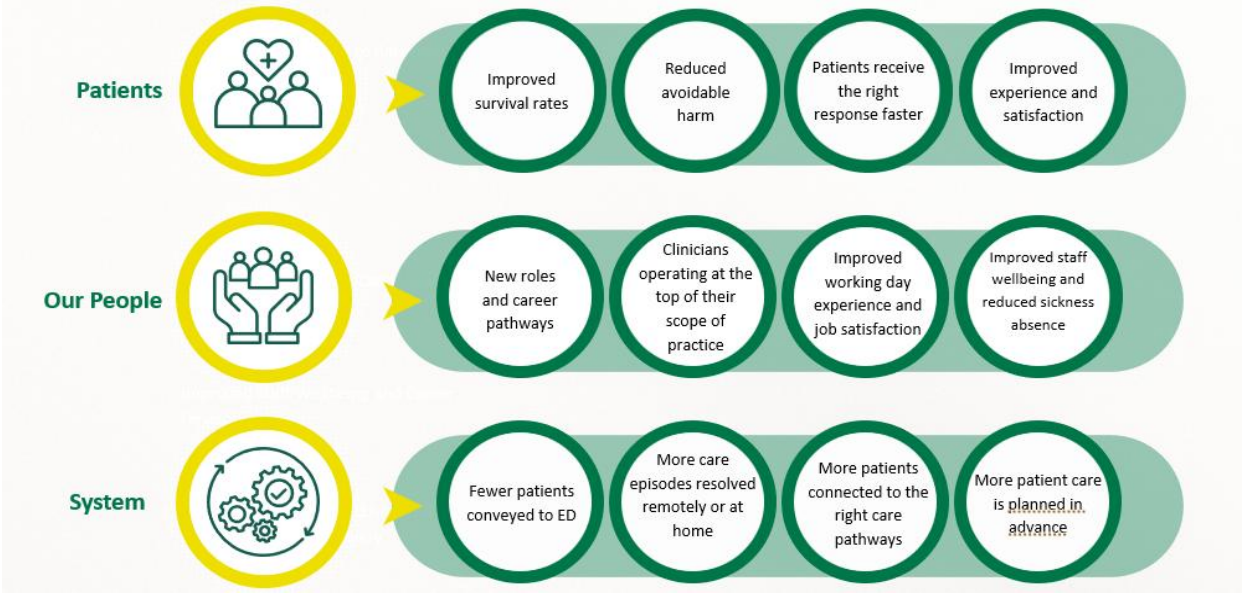
Over the last decade, the Trust has been at the forefront of clinically led pre-hospital emergency and urgent care, with a focus on providing patients with high quality care and service.

In 2024, the Trust launched its ambitious Clinical Model Transformation (CMT) programme which moved forward the existing clinical response model, first introduced in October 2015, to an integrated clinical services model. This move was prompted by a recognition that many patients were not being well served by the existing model of care and that there was a pressing need to ensure the provision of clinically safer services, reducing harm and enabling more people to receive the right care at home or close to home.

The new model brings together three core services - Emergency Medical Services (999), NHS 111 Wales, and Ambulance Care (Non-Emergency Patient Transport Service – or NEPTS) – into an integrated, clinically-led service. The advent of the refreshed model, with its focus on "no wrong door" for patients and equitable access to services based on clinical need, regardless of the method of contacting the ambulance service, is based on a number of key principles:

- clinically led - more clinical input earlier and throughout the patient's journey, with clinical outcomes being the driver for change
- connected - better connections between systems, processes and people to ensure that patients get the right care, no matter what their access point
- care planning - personalised care plans with strong clinical oversight until patients' needs are met
- choice - more options for face-to-face assessments, allowing safe, home treatment and fewer Emergency Department visits
- collaboration - stronger partnerships with national and local health organisations to provide the right care pathways closer to home.

The evolution of the model complements the new Welsh Government ambulance performance framework and is focused on optimising the way care is delivered with a sharper clinical focus, with expected benefits as outlined in the visual below.



Long term modelling shows that, as the model embeds and demonstrates its benefits, the balance of resources should be able to recalibrate, so that more resources are directed to the access points in NHS 111 Wales, 999 and ambulance care and other alternatives to a face-to-face response, with a potentially reduced requirement for emergency ambulances. However, this substitution of resources is likely to take an extended period to be fully realised and will need to be balanced with the Trust's ability to mount a major incident or mass casualty response.

Detailed below is further information on how the Trust is focusing on improving access to clinical services, in terms of timeliness, safety and effectiveness, through its refreshed clinical response model, as well as more granular detail on individual service performance and the experience and outcomes achieved for patients.

999 Emergency Medical Services

One of the key impacts on delivering Emergency Medical Services (EMS) this year has been the advent of a new ambulance performance framework, the result of a review commissioned by Welsh Government into the appropriateness of the previous framework following a recommendation from the Senedd's Health and Social Care Committee.

The new framework has a clinical focus and, while a time-based metric has been retained for the most critical of calls where patients are in a life-threatening condition, the focus is now very much on the improvement of clinical outcomes. In parallel, and as outlined above, the Trust has also continued to evolve its clinical response model, ensuring that clinical review and assessment come earlier in a patient's journey and that patients receive the clinical support most appropriate to their needs.

While the impact of both the new framework and the refreshed clinical model will be the subject of a full academic evaluation, the early evidence detailed below, together with more detail on both developments, suggests they are having some positive impact. Additionally, the introduction of the ambulance handover 45 initiative by Welsh Government, which requires health boards to release ambulances from Emergency Departments within 45 minutes of arrival, has been a very welcome development. There have been some significant improvements in timeliness of hospital handover in the majority of health board areas, which has improved ambulance availability to respond to patients waiting in the community, although the time lost is still double the time that is built into our rosters which in turn are based on an expected 15-minute handover.

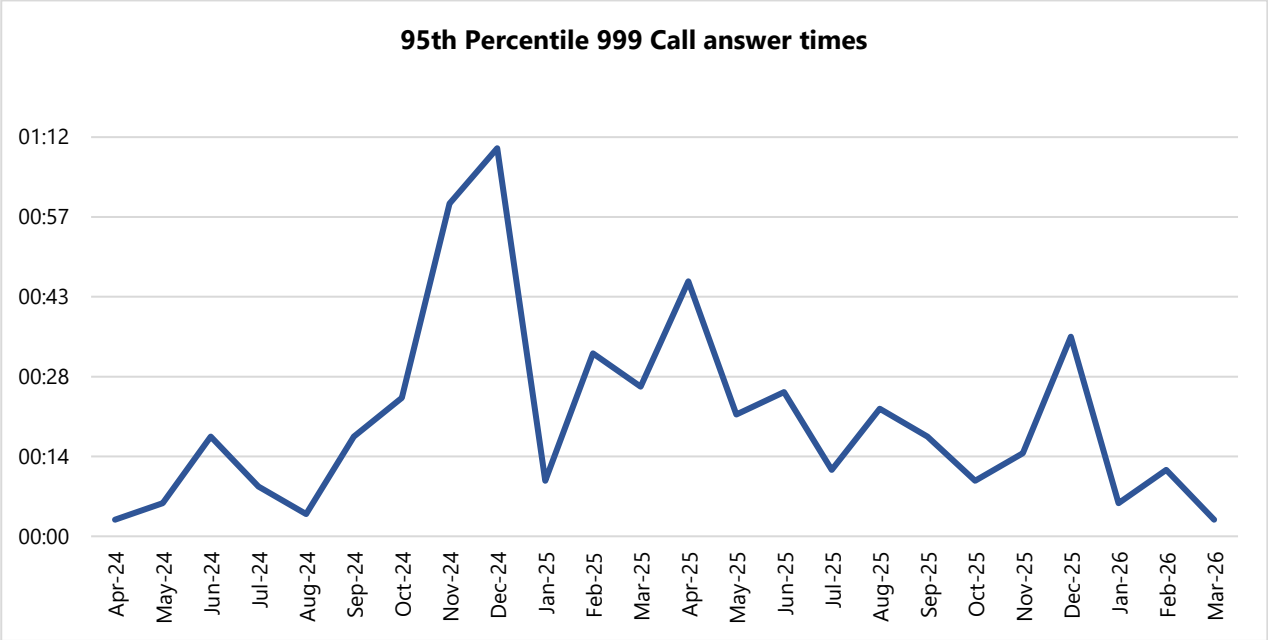
It is that improved ability to respond to waiting patients which both improves clinical safety and outcome for patients. However, it also means that there is not perhaps direct improvement in performance at this stage, as the service responds to previously unmet need. Over time, and as hospital handover reductions become more sustained and universal, there should be a commensurate improvement in performance, aided by further integration and access to community-based services provided by health boards, which will reduce further the level of conveyance to emergency departments, and of course ongoing improvement in the Trust's productivity and efficiency.

The paragraphs below provide more information on EMS performance, which is assessed through a range of response time metrics, clinical indicators, and outcome measures, some of which have changed during the course of this financial year as a result of the introduction of the new ambulance performance framework.

Demand and call answering

In the last 12 months, the Trust received 549,000 999 calls, which related to 420,000 incidents. Incident demand fell by 3% compared to the previous year.

Call answering performance remains positive and compares well with other UK ambulance services. In the last 12 months, the median time to answer calls has been one second, and the graph below shows that there has been some reduction in the longest waits (95th percentile), which stood at 36 seconds in December 2025. The Trust maintained its 'Centre of Excellence' accreditation from the International Academy of Emergency Dispatch, recognising quality use of the Medical Priority Dispatch System for 999 call triage.

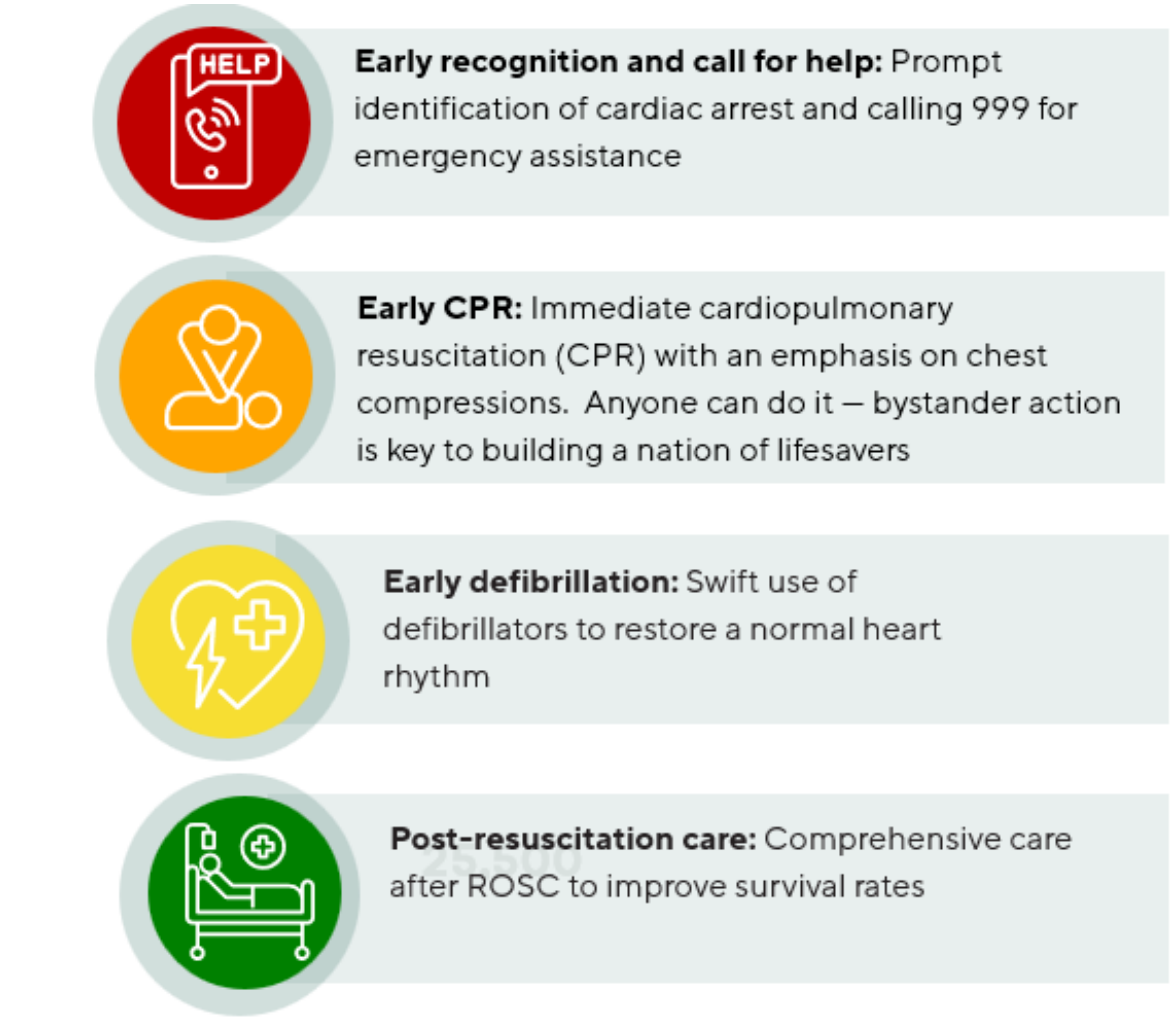


Performance in Purple Arrest and Red Emergency (previously Red) categories

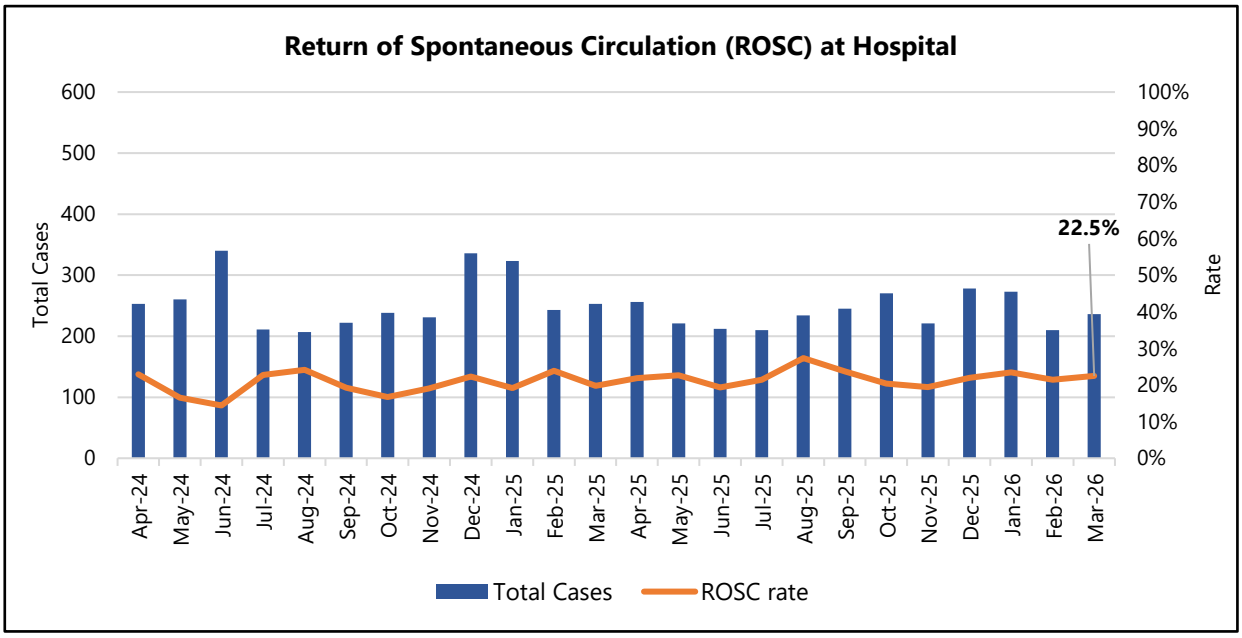
From July 2025, the Purple Arrest and Red Emergency categories were introduced for those in respiratory or cardiac arrest, as part of the new ambulance performance framework.

For patients in cardiac or respiratory arrest, there is clear evidence linking improved outcomes and the chain of survival - a series of critical steps that improve the chances of survival. These steps are outlined in the diagram below and reflect the approach taken to arrest by the Trust. By focusing on this across the system, the expectation is that more lives will be saved. Now that the Trust also incorporates Save a Life Cymru, there is a better opportunity to create "a nation of lifesavers" in Wales through integration of public education programmes encouraging more people to learn cardiopulmonary resuscitation (CPR) and how to use a public access defibrillator.

The Chain of Survival



For Purple Arrest patients, the primary outcome measure is the percentage of people to have a heartbeat restored after a period of cardiac arrest which is subsequently retained until arrival at hospital (Return Of Spontaneous Circulation (ROSC)). Other measures linked to the Chain of Survival include the time to commence CPR and time to defibrillator at scene/patient side.



ROSC rates are higher than they were a number of years ago but have stabilised in the last 2 years, with variation seen each month. The most significant improvement in performance is likely to be achieved through delivery of the whole system out of hospital cardiac arrest plan, ROSC performance is kept under constant scrutiny to understand what more can be done to improve performance, acknowledging that such improvements will be incremental and subject to a number of variables. As the frequency of out of hospital cardiac arrest cases is relatively low, there is variance in the performance on a month-to-month basis, as such it is critical to view this as an overall trend over the longer term.

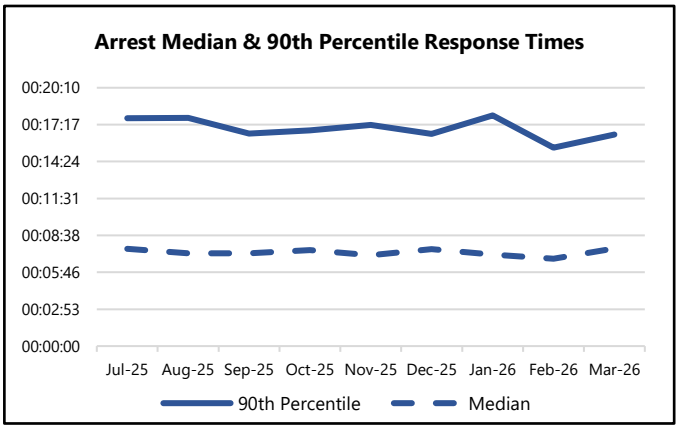
For Red Emergency patients, due to the breadth of presentations within this category, a range of further clinical outcome and indicator measures have been agreed and published from July 2025, including pain scores and oxygen saturation improvement as a result of clinical on-scene treatment and intervention.

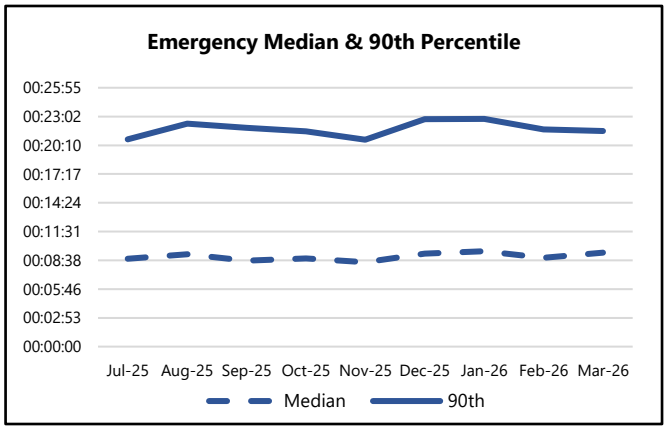
The Purple Arrest and Red Emergency categories are equally prioritised, i.e. there is no distinction between them in terms of time to dispatch. The response times that are monitored for both categories are the same and include a median ambulance response time target range of six to eight minutes and 90% receiving an ambulance response within 20 minutes.

The Trust has responded in a timely way to Purple Arrest incidents, with response times within the target parameters. Despite Purple Arrest and Red Emergency categories being equally prioritised, response times are unfortunately slightly outside target parameters for Red Emergency patients (median of 9 minutes 25 seconds and 90th percentile of 22 minutes 52 seconds in March 2026).

Extensive analysis is ongoing, but to date, the teams have been unable to identify a single cause of this difference. Time to allocation and travel times to Red Emergency calls seem to be longer, and it may therefore be that as the volumes increase, the need for available resources and for them to be in the optimal location becomes more essential. Improvements would then be seen once only once utilisation rates were lower, which will occur when both lost hours are reduced and demand for Emergency Ambulances decreases through the clinical model transformation programme.

In the nine months from July 2025 to March 2026, there were 874 Purple Arrest incidents a month on average, which equated to 2.5% of the total incident volume and 4,722 Red Emergency incidents a month, equating to 13% of incident volume.





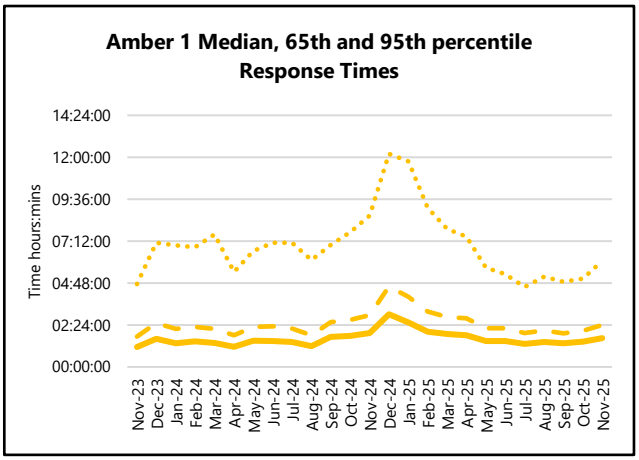
Performance in Amber/Green (now Orange/Yellow/Green) categories

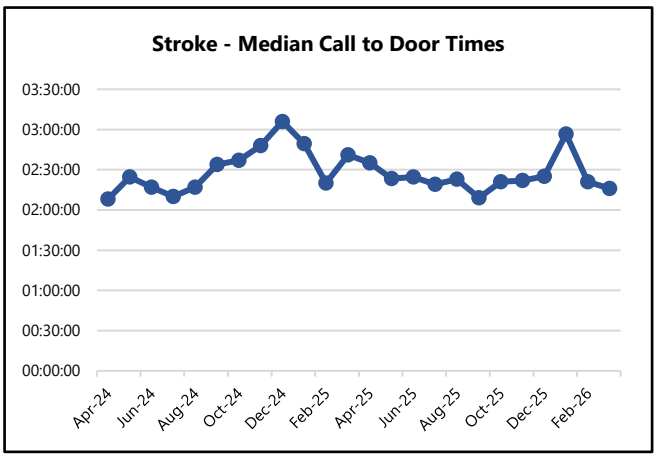
Before December 2025, calls other than Purple Arrest or Red Emergency were prioritised as Amber 1, Amber 2 and Green. Since December 2025 and the introduction of the new ambulance performance framework, the response categories have changed and are Orange (Now), Yellow (Soon) and Green (Planned). In the Trust's new clinical model, remote clinicians work to identify how quickly someone needs a face-to-face assessment (time), what type of clinician is needed (skill) and the reason for a face-to-face attendance (purpose).

The majority of data for this financial year is for responses to the previous categories. These incidents make up the bulk of the Trust's work, with 201,000 or 49% of all incidents in the Amber 1 category in the 12 months to November 2025.

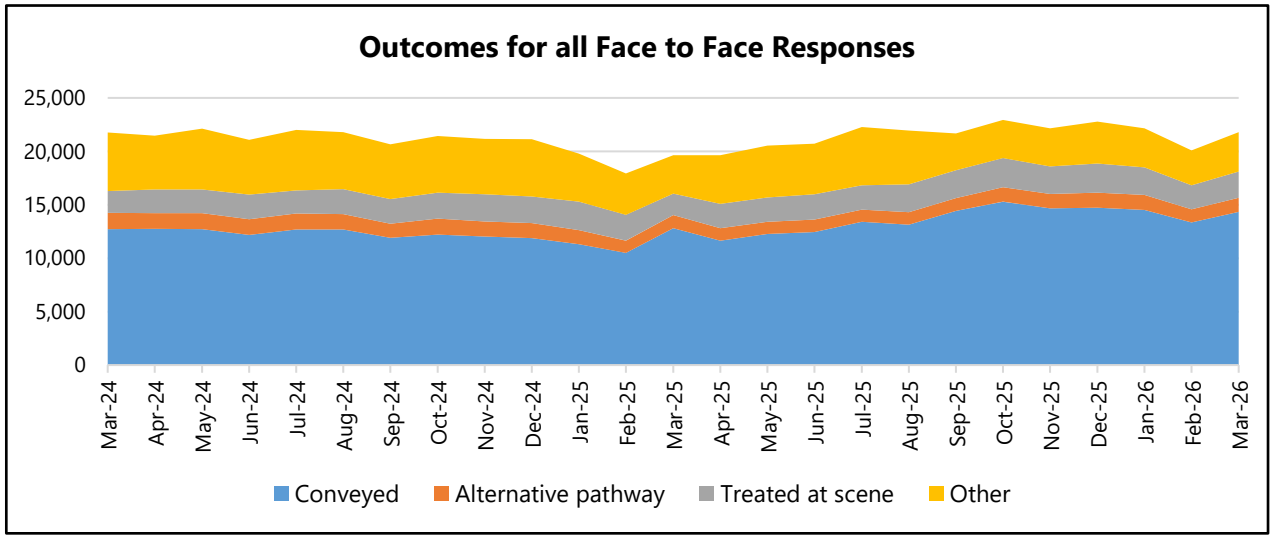
There is no national response time target for these categories of calls, but the Trust has historically modelled on getting to Amber 1 calls within 18 minutes. It is acknowledged that the length of time to respond is far in excess of this and is too long, with the graph below showing that 5% of the patients in the Amber 1 category waited for more than five hours. Patients in the Amber 2 and Green categories wait longer, and response times lengthen for all patients during the winter months, at times of increased demand and system pressure.

Stroke patients may initially be in any one of the categories but, as one of the key clinical indicators, the Trust measures how long it takes from initial call to conveyance to the hospital door, knowing that this is the place where definitive treatment is provided and knowing that time is of the essence. Again, whilst there is no target, an average of 2 hours 22 minutes in November is far longer than the Trust would want. The Trust's risk register reflects this concern and the level of patient harm that these long community waits can bring.



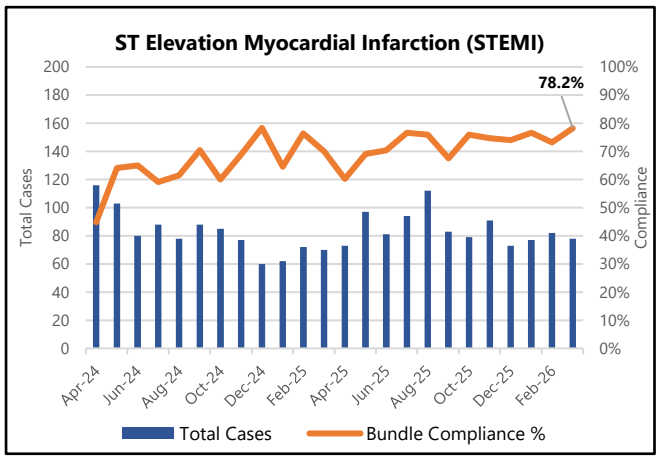


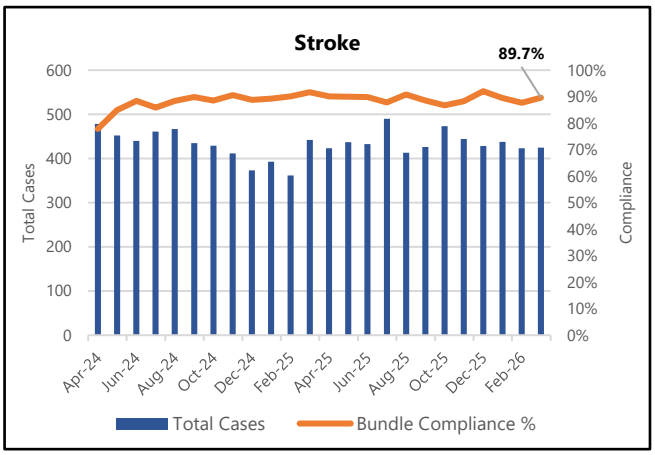
Once a face-to-face resource has been deployed, the proportion of patients who are treated on scene, referred to an alternative community pathway, or conveyed to hospital is monitored. What is currently being seen, as outlined in the graph below, is that numbers of patients conveyed are increasing slightly, and this is as a result of reduced hospital handover delays, leading to greater numbers of on scene responses and fewer ambulance cancellations. Over time, as hospital handovers continue to decrease and as the clinical model continues to evolve, it is expected that the proportion will change, with more treated at scene or referred to alternative pathways.



There is a range of clinical indicators which are monitored to highlight the quality of care provided at scene. As outlined above, some new measures have recently been agreed relating to Red Emergency patients. For other patients, compliance against agreed care bundles is recorded, ensuring that specific groups of patients receive the highest standard of expected care. The graphs below show compliance against the ST Elevated Myocardial Infarction (ADV) and stroke care bundles, which remains below the 95% target.

The variance is mainly caused by clinicians documenting key information in narrative text fields rather than in structured electronic Patient Clinical Record (ePCR) fields, which means actions they have taken are not counted toward Clinical Indicator compliance. To address this, ePCR changes are underway to make it easier for staff. The Trust's Learning and Development Team and Senior Paramedics are reinforcing the need to use structured fields rather than relying on narrative. Clinical audit will continue to be used as a tool for more detailed review to confirm that improved documentation reflects actual care.



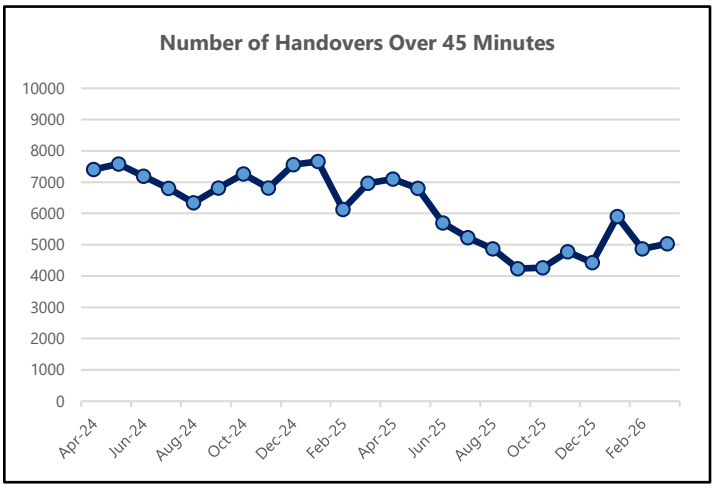


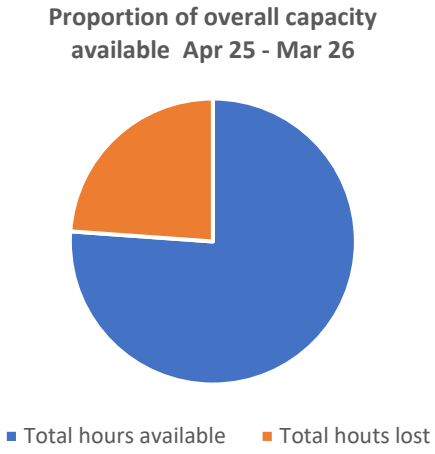
The Trust has taken many mitigating actions, including the evolution of the clinical model, to manage demand, improve efficiency and to reduce the numbers of patients being conveyed unnecessarily to Emergency Departments. However, one of the factors which has been hard to mitigate has been the loss of hours as a result of ambulances waiting to hand over their patients at Emergency Departments.

The Trust's two highest rated risks relate to its inability to reach patients and the harm that is causing (risk 223), as well as delayed access to definitive care as a result of hospital handover delays (risk 224). Improvements in patient flow and a reduction in hospital handover waiting times have been priorities for the Cabinet Secretary and improvements have been seen in a number of areas, leading to a recent reduction in risk 223 for the first time in many years.

Specifically, there is a current imperative to eliminate the numbers of ambulances and patients waiting more than 45 minutes, noting that the updated Welsh Government Ambulance Patient Handover Guidance of January 2026, confirms that hospital handovers should be completed within 15 minutes. Whilst the graph below shows the improvements being made, nevertheless, more than 5000 patients waited more than 45 minutes in an ambulance outside an emergency department in March 2026.

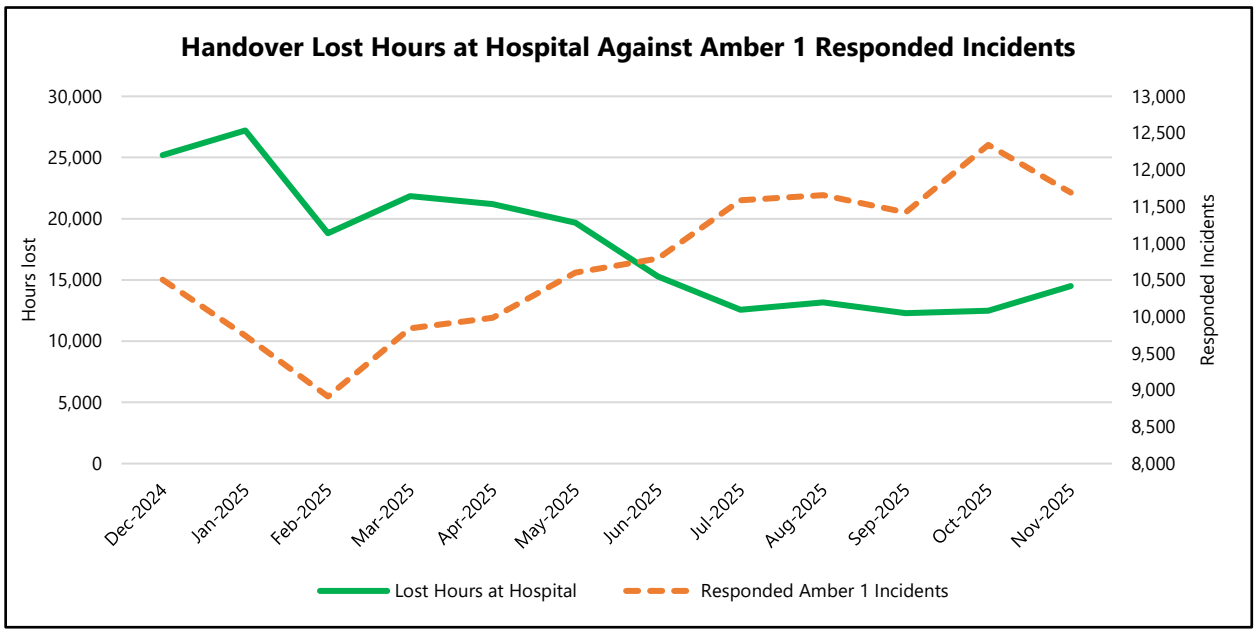
The impact on patient experience and patient care is not the only negative consequence. These extended waits also prevent the ambulances from responding to other patients in the community. Over 12 months, nearly a quarter of all emergency ambulance hours were spent outside an emergency department.





That said, the overall hospital handover improvement is welcome. The key now will be for such improvement to be universal and sustained, which will significantly improve ambulance availability. As mentioned previously, it is important to note that this may not translate immediately to improved ambulance response times, but there is already an increase in capacity to see more patients as shown in the graph below, with the commensurate reduction in ambulance cancellations.

By extension, this provides an opportunity for more patients to be treated at scene, potentially reducing the flow of patients into emergency departments, particularly those who might previously have chosen to cancel an ambulance following a protracted wait and attend under their own steam. Similarly, it reduces the chance of a patient deteriorating such that their clinical outcome is diminished if a timely response can be made. The risks referred to above are reviewed monthly and all mitigating actions both that the Trust are managing and that are being driven in the system, are overseen by the board bi-monthly in a standalone assurance paper.



Remote clinical assessment and decision making

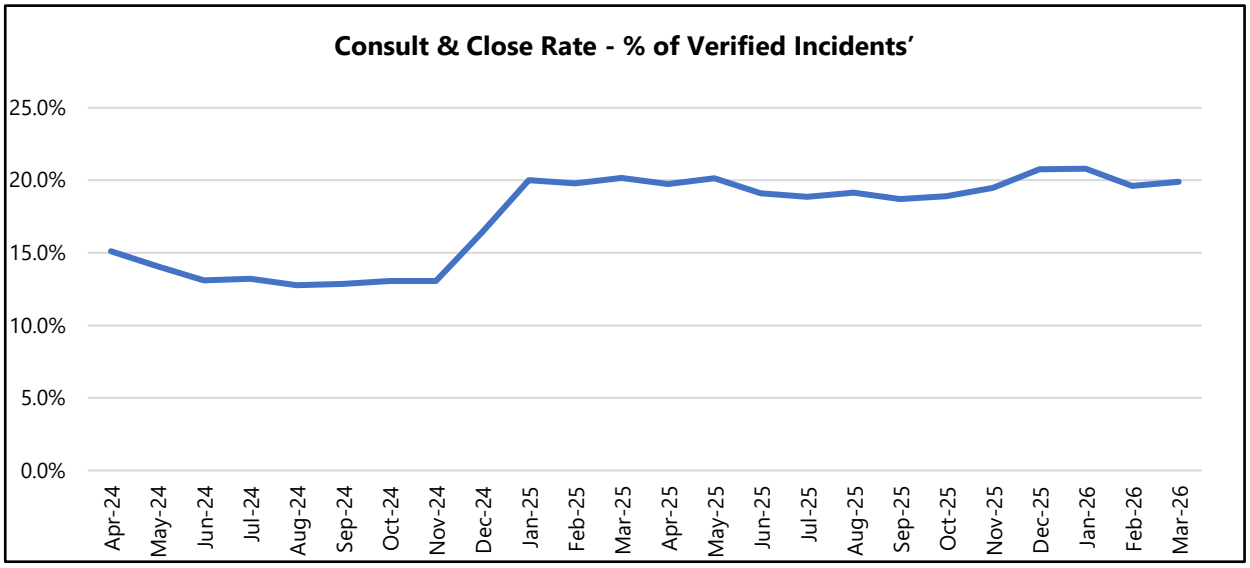
Whilst the Trust has employed and utilised remote clinicians to provide assessment for certain groups of 999 callers for many years, the refreshed Clinical Response Model has placed a greater focus on this element of the pathway.

A proportion of calls is auto dispatched with no remote clinical intervention, notably those for patients in an immediately life threatened condition, with a number of lower acuity calls directed immediately to the remote clinical assessment team.

Clinical Navigators were introduced in December 2024 and these senior clinicians now provide a rapid clinical screen for the remainder of calls (57% of all 999 calls in 12 months Mar 2025 to Feb 2026), using their clinical knowledge and expertise to stream patients to the most appropriate Trust service. They quickly decide if an emergency ambulance is needed right away or if patients require a specialist community response or further remote assessment. In the 10 months since they have been fully operational, they have streamed 57% of calls for further remote clinical assessment.

The total number of calls directed for a remote clinical assessment has therefore increased as a result of this model change, and this allows for further information to be gathered from the patient or caller and for a more appropriate response to be identified to meet their unique needs. Nearly 60% of all 999 calls are now provided with a remote clinical

assessment, up from around 30% a year ago. As a result, more calls than ever are being closed remotely, which reduces demand for emergency ambulance, and directs more patients to appropriate health board pathways, with consult and close rates now routinely above 20%.



Supporting remote clinical assessment, the Trust has created a new volunteer role of Community Welfare Responder (CWR), funded in part (training and support) by temporary grant monies awarded by NHS Charities Together. These responders are tasked with attending incidents as directed by remote-based WAST clinicians. Operating strictly within their defined scope, CWRs perform essential clinical observations and assessments in a direct patient-facing capacity. Additionally, CWRs are prepared to identify and respond to cardiac arrest situations should a patient's condition deteriorate.

Between 1 March 2024 and 30 December 2025, 265 CWR volunteers have been recruited and trained. These 265 CWRs have attended almost 3,000 patients; of those patients attended, 55% (1610) did not require conveyance to hospital. In addition to the data on patient conveyance, there is anecdotal evidence that highlights the valuable ancillary care provided by Community Welfare Responders. Their support extends beyond clinical duties to include feeding and changing babies, assisting with toileting, preparing food and drinks for unwell patients, and offering emotional support and comfort to patients and their loved ones.

The Falls Desk is a service that is currently being piloted in the remote clinical assessment team, having received non-recurrent funding from Welsh Government. It went live on 12 November 2025 and integrates the allocation of falls responders and remote clinical assessments. This initiative aims to enhance patient experience, improve clinical outcomes, reduce long lies, and mitigate the impact on NHS Wales from unnecessary conveyances to Emergency Departments and extended hospital stays.

Resource Coordinators ensure the prompt dispatch of falls responders and volunteers to patients, maximising their utilisation and impact. The clinicians contact the patient or their companions to assist them off the floor safely, provide medication advice, and assess any injuries to inform the optimal clinical response as part of a care plan. Once a falls responder is with the patient, the clinician remotely assesses the patient's clinical needs via video or phone, collaborating with our Advanced Paramedic Practitioners (APPs) embedded in the local health board SPoAs to manage the patient's care as close to home as possible.

Since go live and to the end of December, to the end of March 2026, the Falls Desk has managed over 3,430 incidents. On 3,380 occasions advice was provided to patients who had fallen – 2,528 were provided with advice within two hours of the initial 999 call. This ensured patients were given targeted hydration, nutrition and movement specific advice. 582 patients were provided with support so that they were able to be lifted from the floor, with access to appropriate remote clinical advice provided by the desk.

Care Planning has been introduced as a core component of remote clinical assessment focusing on how the Trust can better hold care while exploring the most effective or available community-based service to support keeping the patient at home. The Care Planning Desk plays an important role in the effective deployment of CWRs. It has been a key part of the Contracts for Innovation Wales project that the Trust has undertaken with Luscii utilising secure clinical solution to aid recording and monitoring of diagnostic results and led the approach to developing the dedicated Falls Desk and Respiratory Desk pilot. Care Planning clinicians are experienced remote clinical advisors who genuinely add value to the patient’s experience by assessing and mitigating clinical risk, offering confidence to patients and their loved ones that they are being supported while alternative pathways are found and, maximising the opportunity for timely appropriate interventions to be deployed by the Trust or health board-based care.

Continuous clinical improvement

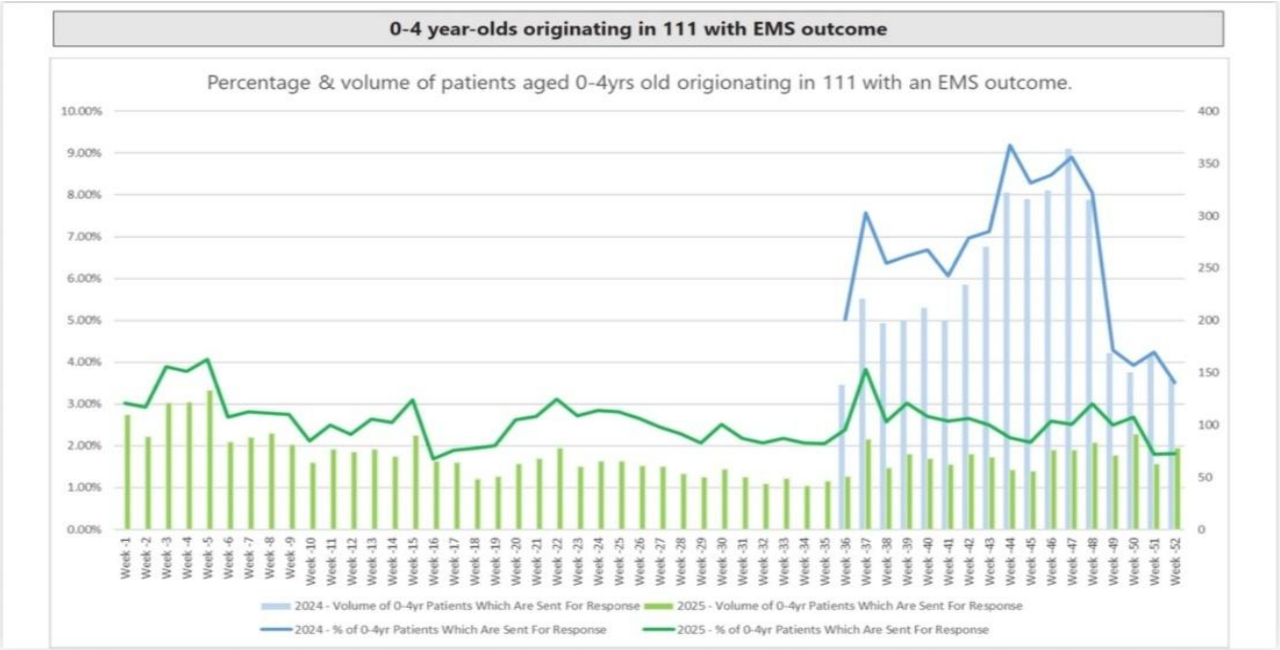
The Trust continually looks for ways in which to improve patient care, outcomes and experience, as described elsewhere in this document.

The Trust looks for ways to better utilise its staff, both changing the mix of skills to better meet individual patient need and optimising the efficient and effective of available staff:

- To support the increase in numbers of remote clinical assessment required as part of the evolved clinical model, the number of generalist remote clinicians has increased by 12 WTE (whole time equivalent) in 2025/26. This has contributed to increased consult and close rates.
- The number of APPs has risen by a further 10 this year. These Master's-level clinicians work both in remote assessment and face-to-face on scene. APP Navigators are now co-located with every health board as part of their single points of access (SPoA), which is allowing a true multi-disciplinary and multi-organisational review and response to more complex calls. With 40% qualified as independent prescribers, the ability of APPs to treat and close an episode of care on scene is significantly enhanced – a 32.6% see and treat rate in the last 12 months. Tests of change have also been undertaken to move to responding APPs being provided with a schedule of planned visits which will increase the numbers of patients they can treat each shift – this went live in February 2026 and will lead to increased see and treat rates.
- A different response model for mental health patients has been piloted, which includes mental health clinicians in control centres, supported in South-East Wales by a mental health clinician in a car. This model has now been evaluated and has now been discontinued on the basis that the Trust cannot evidence sufficient value, with mental health resources to be concentrated in the remote setting were clear evidence does exist. This will be discussed with Welsh Government colleagues to consider potential system wide implications.
- Recognising the diversity of patients accessing ambulance and 111 services and their attendant clinical needs, the Trust has also recruited some specialist clinicians to support clinicians working remotely and, in the field, to offer optimum care. This means increasing the generalist scope of practice of our paramedics and nurses to ensure they are more confident working with patients to access community and primary care-based services where clinically appropriate and available. Specialists include a midwife, respiratory specialist, paediatric specialist and substance misuse specialist.

Analysis of 999 demand shows that the highest number of calls are from patients who have fallen, have breathing difficulties or have chest pain. Our clinical teams continue to work on improving services for these groups of patients, particularly focusing on how conveyance to hospital can be avoided where appropriate:

- More than 56,000 incidents per year relate to falls which equates to around 13% of all demand. The Trust commissions St John Ambulance Cymru to provide Level 1 falls response vehicles across Wales and provides a Level 2 service jointly with Aneurin Bevan University Health Board – together these resources respond to around 10,000 of these incidents. Clinical leads are heavily engaged in the Falls workgroup established by the Six Goals Programme and as outlined above, have established a falls desk which is ensuring better utilisation of our responding resources as well as allowing more patients to get off the floor safely through remote support. In addition to improvements seen through the falls desk, in 2025, overall 'attendance at scene' time to falls incidents (by all vehicles) has been achieved within 2 hours for 64% of incidents during the hours of 07.00-19.00hrs, with an ambition to achieve 70%. Discussions with Welsh Government colleagues and commissioners have highlighted the potential for additional focused collaboration to improve outcomes for falls patients which will be a focus for the Trust over the coming months.
- WAST is delivering a coordinated programme to strengthen respiratory pathways across Wales, with a focus on early identification, safe triage, and improved use of community-based care.
- In 2025, the service developed the first Paediatric Respiratory Emergency Prediction (PREP) score to support more accurate assessment of 0–4-year-olds presenting with respiratory distress. The graph highlights the level of reduction that has been seen between the blue line (showing 2024) and the green line (showing 2025).



- To reduce unnecessary escalation to 999, NHS Wales 111 has implemented targeted interventions including improvements to the Clinical Prioritisation and Streaming System (CPSS) (a clinically based triage tool, used by our calls takers to stream less complex calls through to the correct service without the requirement to use a clinician), strengthened clinical validation prior to transfer, enhanced staff training from Specialist Clinical Leads, and updated hospital handover processes between 111 and 999.
- The Trust has introduced self-management tools, enabling clinicians to safely conclude care episodes with self-care advice.
- From February 2026, a dedicated respiratory desk is being piloted to coordinate patients presenting with breathing difficulties and support the expansion and co-development of health board–specific respiratory pathways.
- In Betsi Cadwaladr University Health Board, APPs will also begin a trial of point-of-care testing for suspected infection, supporting increased access to heart failure pathways, virtual warding, and community-initiated treatment

Collaboration with system partners, and in particular with health boards, is critical to securing the best outcomes for patients, especially as the Trust seeks to find alternative pathways and avoid unnecessary conveyance to hospital. The Trust has worked very closely with the Six Goals Programme and health boards - being represented on each of the programme groups - on SPOAs, SDECs, Clinical Consultation before Conveyance and Falls services. The Trust has co-led a number of regional workshops with Hywel Dda University

Health Board and Swansea University Health Board, considering in particular how the Trust might collaborate on remote clinical assessment.

Forward look

As the Trust looks towards its plan for 2026/27, there are a number of key priorities which will ensure further improvements. The Trust moves into the final year of its Clinical Model Transformation Programme, with a number of remaining actions, including the full integration of its 111 and 999 remote clinicians into one remote integrated care service. This supports the ethos of 'no wrong door' and pooling clinical resource to better service all patients, regardless of the chosen method of contact.

However, the focus is predominantly on how the model is now embedded and ensuring that benefits are fully realised. Edgehill and Swansea Universities have been commissioned to undertake an external review that will be completed over a 2–3-year period. Earlier, interim evaluations will be completed on specific areas of the model, including two on the new ambulance performance framework to be completed in the next 12 months, recognising that it has been introduced initially as a pilot.

There will also be a strong focus on improving productivity, efficiency and value. As an example, work is underway to rebalance the skill mix on Emergency Ambulances which, as well as reducing / containing cost over time, will also maximise the utilisation of the skills of the Trust's new band 5 Emergency Ambulance Practitioners (EAPs).

With an increased emphasis on patient outcomes, it is important that there is collaborative work with Digital Health and Care Wales (DHCW) and others on the design of national data sharing mechanisms and lawful frameworks to enable more robust cross organisational data linking. Such connected intelligence will support the Trust in fully understanding the outcomes of the changes it is making, as well as understanding where there are further opportunities to add value across the wider health and care system, which is why this work is critical for both the Trust and NHS Wales more broadly.

There are some significant opportunities emerging for the Trust to continue to make that system-wide contribution through the creation of more opportunities for strategic dialogue and collaboration with partners and through participation in Welsh Government initiatives such as the Community By Design programme, which affords the Trust an opportunity to contribute to wider, system-based solutions to improve patient outcome and experience.

NHS 111 Wales

For many patients, their first point of contact with urgent or emergency care is the 111 service, with 5.3 million visits to the website and more than one million telephone calls in the last 12 months.

The NHS 111 Wales digital offer

While recognising that much work and investment is needed to bring the website to a "best in class" standard, the Trust is committed to making incremental improvements to the NHS 111 Wales digital offer, pending decision on future levels of investment.

Discussions are ongoing with Welsh Government and with commissioners around the mechanisms to develop the digital front end into a sustainable service which matches the digital ambitions set out by the Cabinet Secretary and which has the potential to create greater value in the urgent and emergency care system. Non recurrent monies provided each year by Welsh Government have been welcomed.

With a corporate risk identified in relation to adequate maintenance of the digital symptom checkers, the Trust has utilised its discretionary capital to commence a programme of work to identify and implement a compliant and effective Online Symptom Checker tool. Work is progressing well, with the new updated symptom checkers due to go live in June 2026. This will be integrated with the clinically led, Welsh solution software system used for 111 callers (CPSS) which will allow for the prioritisation and streaming of patients to appropriate outcomes, potentially reducing the number of digital interactions in which patients are directed to call 111.

In collaboration with Robotics AI, the Trust has developed a 'chatbot' virtual assistant on the NHS 111 Wales website, which provides immediate responses to user enquiries and streamlines access to information. Accessible in multiple languages, including Welsh, the virtual "AIBot" assistant offers a more interactive and user-centred experience. Since launch, AIBot has supported thousands of user interactions (over 45,000 in the eight months to March 2026), demonstrating strong uptake and engagement, with ongoing performance monitoring and user feedback used to continuously refine content, conversational flows and escalation routes. The solution has also received external recognition, having recently been shortlisted for a national excellence in digital healthcare award, reflecting both its impact and wider relevance across urgent and emergency care.

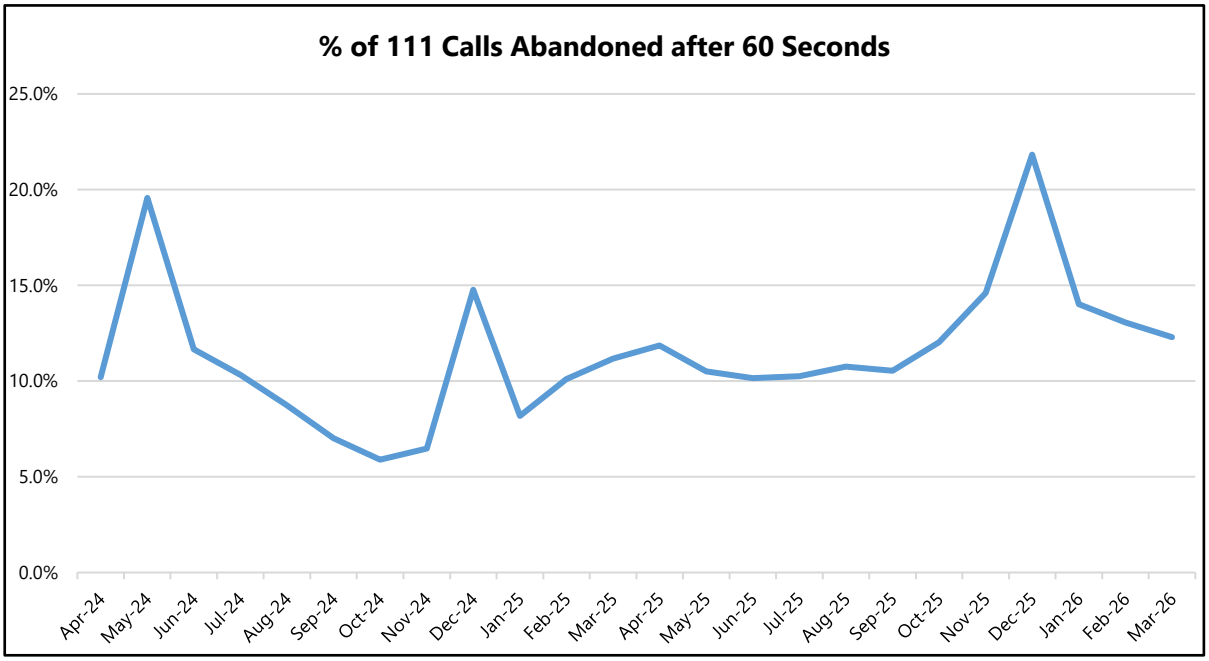
Work is underway to understand the further potential of agentic AI within the confines of the existing NHS 111 Wales website. In addition, Welsh Government support has enabled the Trust to progress WhatsApp integration, replicate NHS 111 Wales web functionality through virtual agent chat interactions, expand language coverage, and explore the redesign and improvement of prescription reordering pathways.

Alongside this delivery, patient feedback is actively being collected and analysed, with more than 1,000 individual pieces of feedback received to-date. This feedback has been mixed, with a significant proportion highlighting positive user experience, speed of access and clarity of information, alongside constructive feedback seeking additional functionality, improved clinical depth and smoother escalation. Many of these requested enhancements are dependent on integration with a modern symptom checker which would unlock more personalised and clinically rich interactions, and this will be enabled once the symptom checkers are live from June 2026.

NHS 111 Wales telephony service

The Trust measures the quality of the service it provides through call answering times, abandonment rates and clinical ring back times. Historically, the nominal target has been to keep abandonment rates to lower than 5%. As can be seen in the chart below, this has rarely been achieved. A full demand and capacity review undertaken by specialist contractors Opta-Shift last year has confirmed that the Trust has insufficient call handlers to achieve this level of performance.

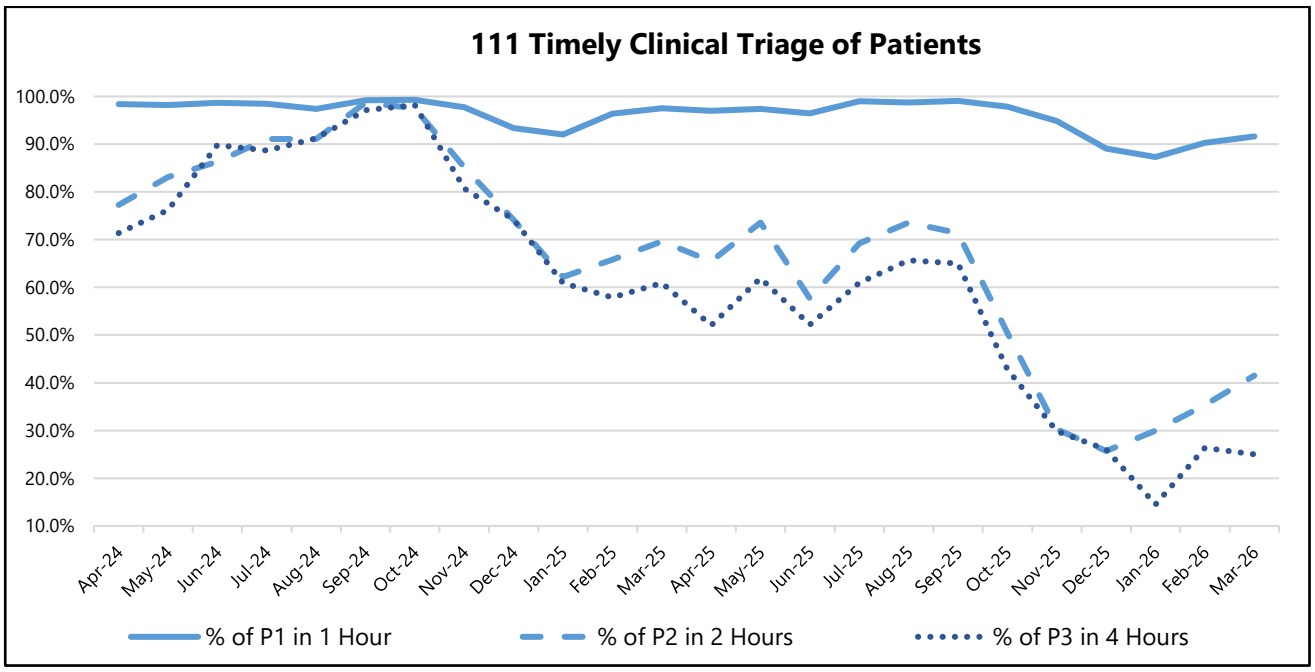
Current commissioned numbers (190 WTE) allow for performance between 10 - 15%, or alternatively, a further 22 WTE call handlers would be required. However, this would still be insufficient to meet the hourly, daily and weekly peaks that are experienced in this service, particularly during bank holidays. With no investment in 2026/27, this is unlikely to be resolved other than exploring further ways of managing demand in other ways, including the use of a digital front end.



The Trust is actively looking at what can be done in terms of process and productivity within the existing commissioning envelope to improve performance and is currently undertaking a full re-rostering exercise within the 111 service, which will see shift patterns more closely aligned with expected demand and provide a better work experience for our people, reducing absence levels. This will be concluded by early 2026/27. Discussions are ongoing with commissioners around appropriate future performance measurement.

Other avenues for improvement will also continue to be explored, including how the development of the digital front-end systems could reduce telephony demand.
The Trust has consistently delivered a clinical ring back within one hour for more than 90% of the highest priority patients. However, performance for lower priority calls has deteriorated in recent months, with some patients waiting many hours for a call back as set out in the graph below. Work is underway to better understand the factors influencing performance. Numbers of the highest priority calls have increased and changes in process and productivity are being considered to improve the experience and outcome for patients with lower acuity needs.

Clinicians are undertaking more clinical reviews than ever and there is good productivity from that perspective. This also underlines the need to explore and optimise digital solutions, which could provide an effective and clinically safe alternative for low acuity callers.

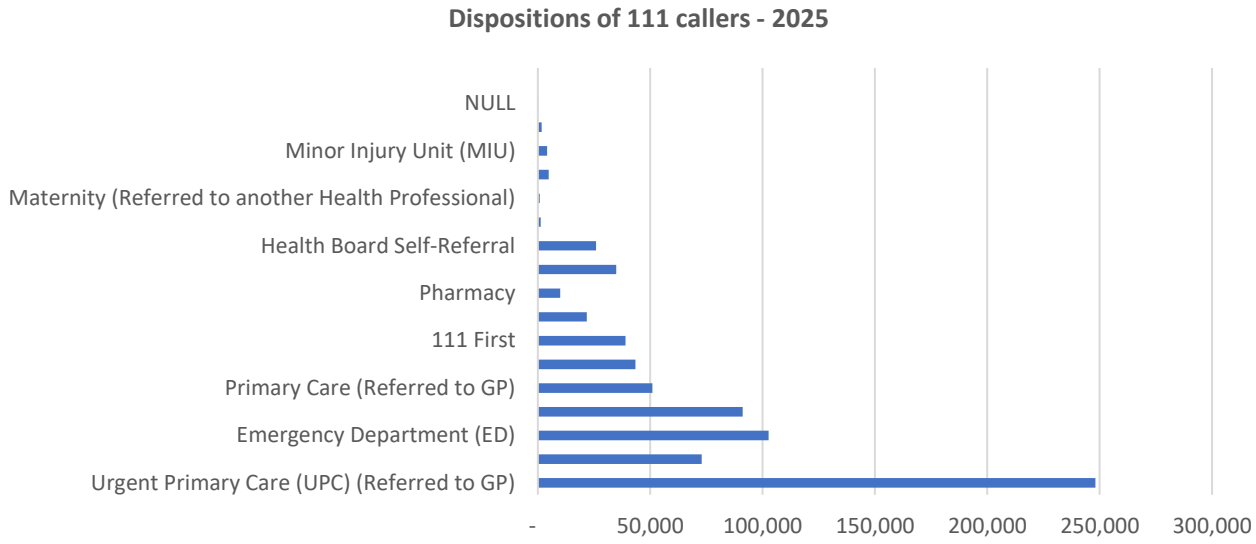


In line with the Trust's evolving clinical services model, from early spring 2026, all remote clinicians, including those who deal with 111 calls and those who deal with 999 calls, will form a new Remote Integrated Care Service (RICS). Clinicians working in this service will be working from a single system that will enable them to support patients based on their clinical presentation and need. This will ensure that the sickest patients are considered consistently across both call types and importantly, will ensure the Trust is better placed to support lower acuity presenting patients access community and alternative care appropriately.

The Trust has also developed capability and capacity to ensure that there is an increase in the scope of practice applied by remote clinicians to better support patients and, as a result of this, support the wider NHS Wales system manage demand more effectively. This includes the previously identified adoption of video call and Community Welfare Responders to support clinical consultation and diagnosis.

Whilst timeliness is a key factor in relation to patient experience and quality, perhaps more important is the extent to which the 111 service is able to effectively and efficiently provide a gateway to the right care for each individual caller.

As the visual below highlights, many callers are directed to urgent primary care services (Out of Hours (OOH)) or to their own primary care practitioners. This is to be expected, as the service was explicitly introduced as a route into OOH services. Around 15% are currently directed to attend an Emergency Department and, whilst this proportion benchmarks well with other UK 111 services, the Trust is working with health boards to find ways of reducing this further and finding more appropriate pathways to maintain patients at home or close to home. This links back to the ambition to increase remote clinicians' scope of practice and use of digital tools to confirm patient self-care plans that could schedule planned follow up access to primary care services or require individuals to self-refer into community-based services, such as community pharmacy.



Three health boards (Swansea Bay University Health Board, Aneurin Bevan University Health Board and Cardiff and Vale UHB) operate a 111 First protocol, whereby agreed categories of patients who would otherwise be directed to the Emergency Department are transferred to their remote clinical assessment teams for further review - in December 3,370 patients were directed to these health board remote teams. Dip sampling has shown that more than three quarters of these patients are successfully managed away from Emergency Department in the three health boards where this is active.

In January 2026, the Trust expanded the criteria for 111 First in Cardiff and Vale University Health Board following successful trials. Those trials showed the volume of patients sent to Emergency Departments could reduce by 40-50%. This approach is being discussed with Aneurin Bevan and Swansea Bay University Health Boards.

Forward look

As the provider of NHS 111 Wales, the Trust recognises the opportunities which the service has for improving patient outcome and experience, as well as smoothing the flow of patients around the system, so that those in need of care receive it at the right time and in the right place. The Trust's IMTP will include a number of priorities including those set out below:

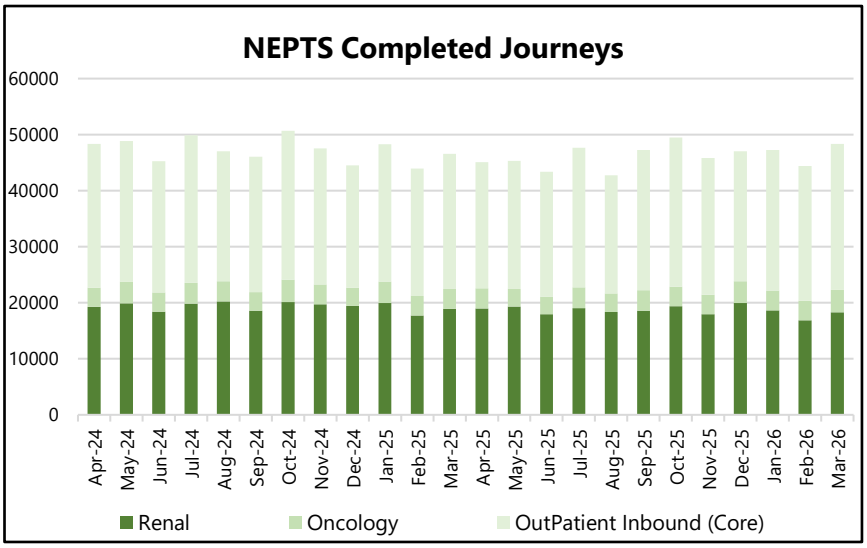
- Where resourcing allows, the Trust will continue to support progress on the establishment of the 111 Wales digital front end as a national, modern gateway for accessing advice and care, helping to enable more effective mechanisms for directing patients to the right care, at the right time. Working collaboratively with partners across NHS Wales, including Digital Health and Care Wales, the Trust will support the articulation of a shared national vision for the future of digital access to urgent and primary care. This includes the potential alignment of the 111 Wales digital front end with the wider 111 service, and, subject to national prioritisation, the coordination of the 111 Wales website with other digital front doors such as the NHS Wales App. These public entry points to the system offer opportunities in future for patient-generated data (e.g. from wearables, health apps, or questionnaires) to also be utilised within the care pathway for more personalised experiences and advice, earlier intervention, and both primary and secondary care prevention.
- As a national provider, the Trust already has a robust Directory of Services (DOS) which is available both internally to our people and directly to the public through the 111 Wales website to offer information and signposting to service users. The Trust is supportive of a single national DOS that can be utilised by all services across Wales and embedded in platforms such as the 111 Wales digital front end and NHS Wales App in order to provide a single-source of truth to the people of Wales in an efficient and credible manner. As such, the Trust is already engaged in the scoping, definition and design of a future national DOS.
- Continuing to improve patient experience and outcomes through a reduction in waiting times for those who call, increased access to alternative pathways such as 111 First, and reducing the numbers of hand-offs including direct booking opportunities and improved collaboration with the clinical support hubs.
- Similarly to the 999 EMS service, linking patient data so that the Trust and its system partners can better understand overall patient outcomes, service utilisation, and system impact is critical, and the Trust is committed to finding a way forward on this in collaboration with partners.

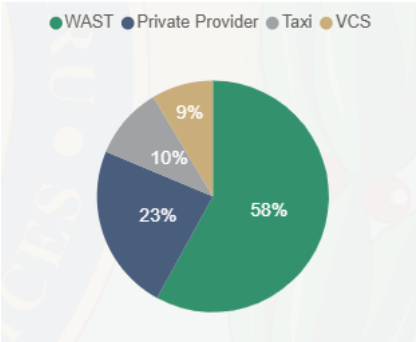
- The Trust will engage fully with the Community by Design programme to explore opportunities for 111 to play a much more integrated role within urgent care.

Non-Emergency Patient Transport Services (NEPTS)

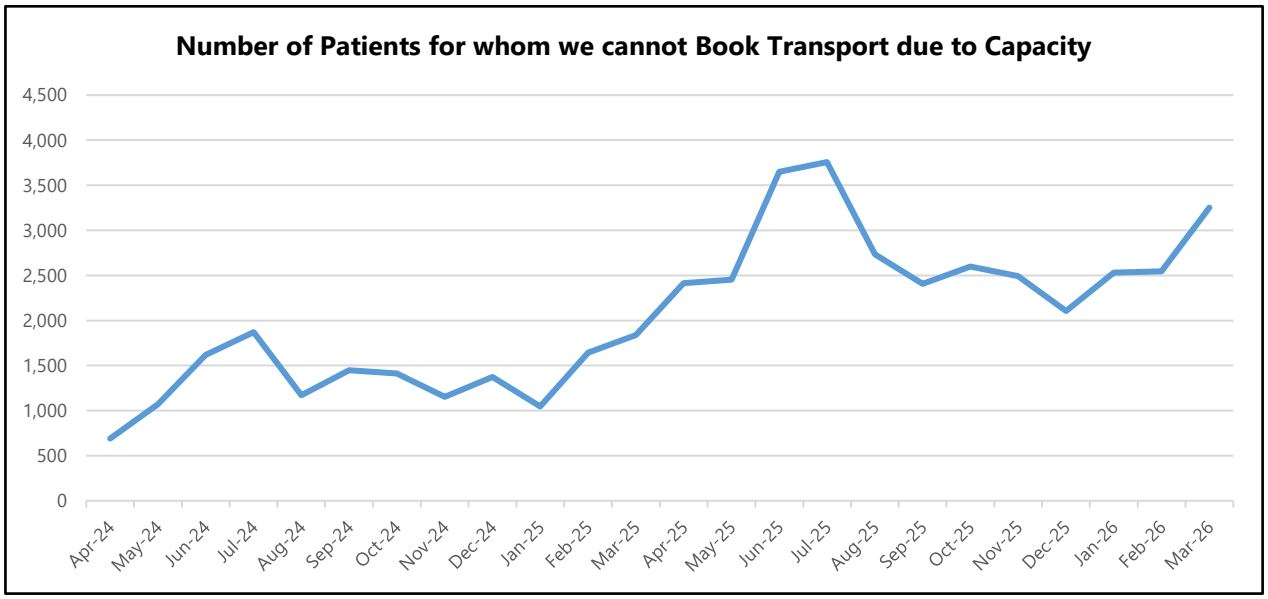
The Trust's Ambulance Care team provides three main areas of service: transport to and from oncology, renal and routine outpatients appointment; discharges and transfers from hospitals; and conveyance of some 999 calls to hospital where the clinical skill set allows.

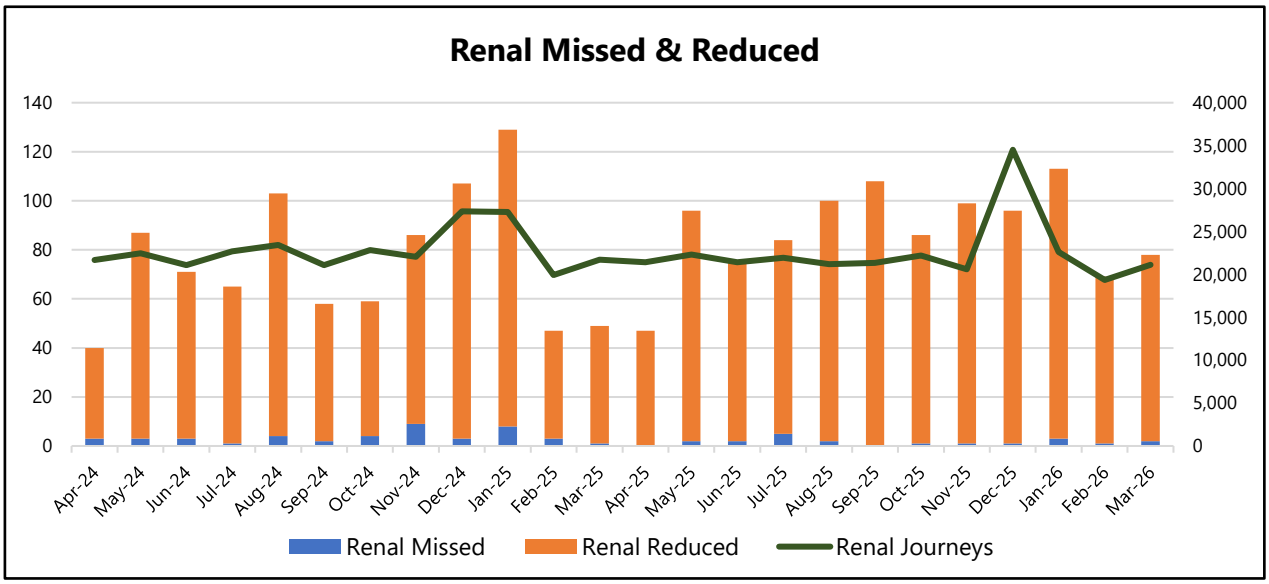
The services support significant numbers of people across Wales, with the graph below showing that circa 46,000 patients are transported to their appointments each month. The service is provided by a range of WAST staff, WAST volunteer car drivers, contracted private providers and taxi services. The private providers are fully commissioned by WAST, with a comprehensive Quality Management Framework in place to ensure services are of a high quality.





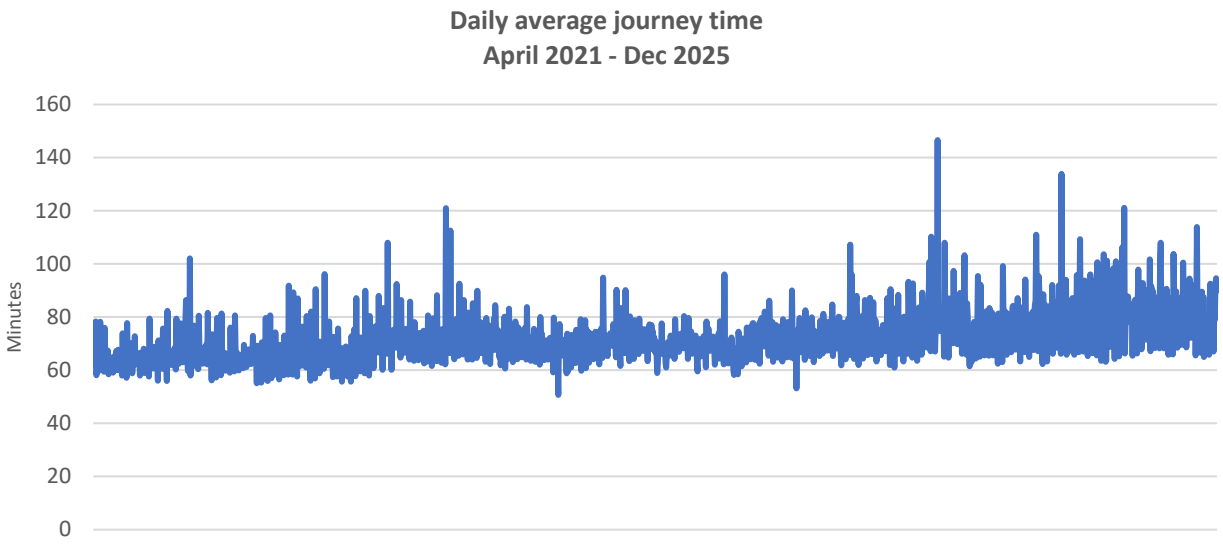
Over the last few years, demand patterns have changed, which has meant that the Trust has been unable to service all of the eligible demand. The result is that there are a number of patients that have their transport cancelled, sometimes at very short notice. This clearly provides a poor patient experience and also has the potential to affect patient health outcomes if patients are unable to access the secondary care that they require. Without linked data, the Trust is not always able to ascertain the outcomes, but it does monitor any cancellations for renal patients – with renal appointments prioritised, these remain very small in number. We also know that complaints about our NEPTS services have risen considerably in the last year or so, something which is of concern and is being monitored for themes and trends.

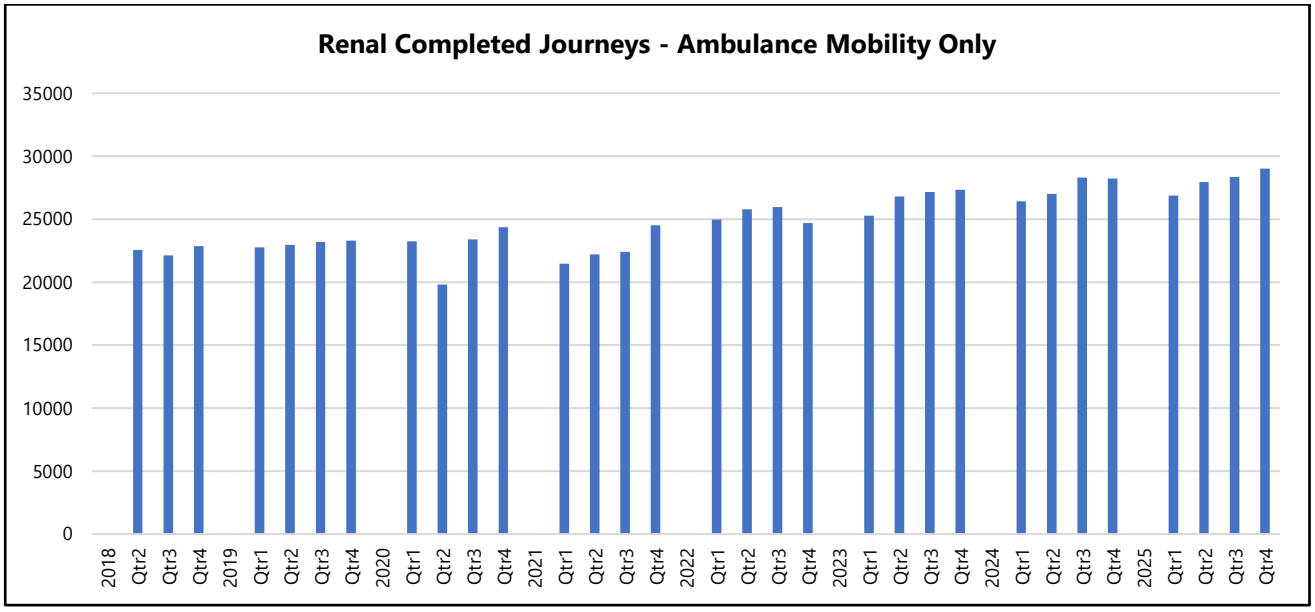




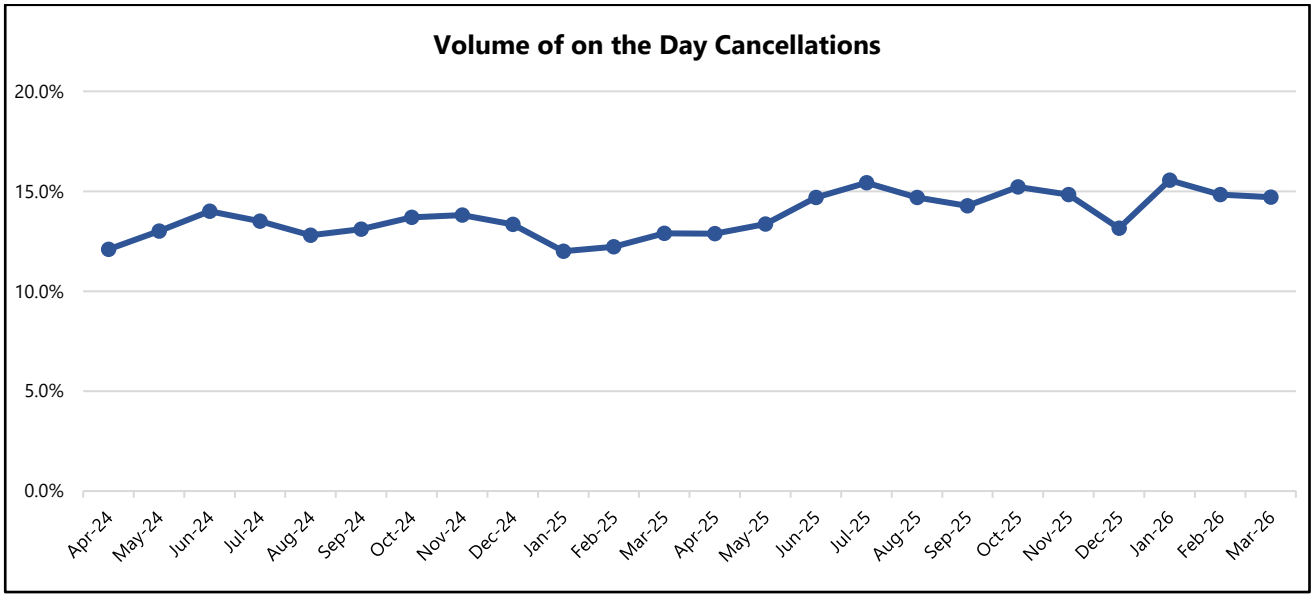
Two of the most significant factors affecting demand have been an increase in the numbers of miles per journey, brought about by centralisation of some services across Wales; and an increase in the acuity of demand, with fewer eligible fully mobile patients and more stretcher patients. As can be seen in the graph below, average journey times have increased from around 60 minutes in 2021 to over 80 minutes in 2025, an increase of 25%. With more than 46,000 journeys per month being undertaken, this is a significant level of additional capacity required.

Since the pandemic fewer patients are transported per vehicle per day. This was originally a function of minimising infection risks but is now something that requires review to increase efficiency and productivity. However, this has to be managed in respect of risk and of further concerns about the length of journeys, with some patients spending many hours being transported as routes become more circuitous. However, the Trust recognises the need for all its services to be as productive as possible, especially where there are known inefficiencies and will seek to address these.





There are also factors which affect capacity, most significant of which is the number of journeys which are planned and then not required. This is often as a result of hospital appointments being cancelled and the NEPTS service not being informed in advance. The level of on the day cancellations is currently running at 15% of all planned activity, which, if reduced, would provide additional capacity to deal with unmet demand.



Notwithstanding these issues, performance against service timeliness indicators is now consistently higher than at any time since the creation of the NEPTS service. The below table shows performance against the key standards for 2025 and 2019; the green highlight indicates measures that are above the expected service standards.

Key Measure	2019	2025	Difference
Inward Outpatient 1	59.4%	72.9%	13.5%
Inbound Oncology 1	62.4%	78.1%	15.7%
Inbound Renal 1	58.6%	73.9%	15.3%
Outbound Outpatient	77.8%	76.4%	-1.4%
Outbound Oncology	77.1%	79.6%	2.5%
Outbound Renal 1	69.1%	75.1%	6.0%
D&T Advanced	67.5%	80.3%	12.8%
D&T Same Day	97.4%	95.3%	-2.1%

Action is required to improve the service that the Trust is commissioned to provide in terms of its ability to meet demand and to reduce the unacceptable levels of cancellations. The Trust works very closely with commissioners and health boards through the JCC's Delivery Assurance Group to deliver the best possible performance for the patient. Actions that have or are being taken include:

- Re-rostering of all Trust resources, to better match shifts with demand. Re-rostering is complex and sensitive and so the Trust is utilising an external partner to work through the detail, including using a number of staff working parties to reach final agreement. Modelling identified that the Trust could make an efficiency gain of +354 patient journeys per week or 18,458 a year whilst also producing workable shift patterns for our people. The new rosters are likely to be implemented in Q1 2026/27.
- This year has seen the introduction of SMS messaging, allowing the Trust to contact patients if their transport is going to be cancelled, providing an improved patient experience offer. Work is ongoing to make this a two-way messaging service, allowing patients to cancel their transport easily.
- In partnership with Hywel Dda University Health Board, work has been undertaken to align and link the health board outpatient system with the Trust's system. This has allowed the Trust to identify hospital appointments that have been cancelled and thus cancel transport arrangements in time to reallocate resource. In the first 5 months of operation, a total of 413 journeys have been able to be cancelled in time to utilise resource elsewhere. Work will be ongoing to roll this out, if possible, to all health boards.
- Modelling has been undertaken on a number of options to reduce cancellations, which will be discussed in more detail with commissioners. Opportunities for the Trust and health boards include reducing eligibility for walking patients allowing more capacity for patients who have to be transported in an ambulance; relaxing performance criteria; reducing wait and return NEPTS vehicle downtime; prioritising WAST transported patients in clinics; and reducing journeys cancelled on the day.
- It would be timely to review NEPTS eligibility criteria, but it is recognised that this a matter for Welsh Government and Commissioners. In addition, there would be benefit in identifying the impact of health board plans to increase the use of digital and virtual appointments. In the meantime, the Trust will continue to work on increasing productivity and reducing inefficiency.

Quality and safety of services and patient feedback

The Duty of Quality has been a cornerstone to the transformation work the Trust has undertaken over the last couple of years. Through the application of this Duty, the Trust has taken a considered approach to how it could play a greater role as a system partner to reducing the level of harm being experienced by patients. The Trust uses quality and continuous improvement methods to test and implement service improvement at a local and national level, it has adopted a robust approach to securing quality impact assessments that includes the creation of a Clinical Advisory Group to review and recommend adoption and, it has adopted a robust quality management approach to securing organisational assurance on service quality.

The Trust consistently aspires to offer a high-quality emergency and urgent care service. However, it is recognised that there are occasions when those standards of care are not met for too many patients. The previous sections have set out some of the reasons that this has been the case, as well as the corporate level risk the Trust is managing, and the many actions that the Trust has been taking, with system partners, to improve care and outcomes. The Trust has consistently sought to be transparent when supporting families who have not experienced the standard of care it aspires to deliver. This is primarily achieved through the application of the Duty of Candour and the dedicated work of the Trust's Putting Things Right team and clinical colleagues from across the Trust who actively support individual cases.

The experiences captured through the Coroner, Medical Examiner and the Trust's complaints profile illustrate the human reality behind system failure: prolonged pain, suffering, indignity and trauma for patients and families as they wait for care that does not arrive in time. This is shared with the Trust Board and Quality, Patient Experience and Safety (QUEST) Committee through both insights reports and through the use of lived experience sharing by patients, family members and Trust staff to ensure that the human toll of failure always remains a conscious priority.

The Trust is not complacent and recognises that there is much to do to minimise harm and reduce variation to improve the experience and outcome for patients. As indicated above, the board and QUEST Committee have received regular updates on actions taken to mitigate harm, and performance reports regularly generate discussion, scrutiny and challenge on what more can be done in this realm. While some actions are outside the gift of the Trust, many remain within it, and there is significant commitment to continue both to

improve our own services, while working closely with health boards, the JCC and Welsh Government to deliver improvements across the system.

Nationally Reportable Incidents and Complaints

For the period April 2025 to March 2026, the Trust reported 53 Nationally Reportable Incidents (NRI) and in March 2026, 19 were overdue for incident closure. Where an NRI or serious incident is identified that is attributable to another party, it is referred to the respective party under the All-Wales Joint Investigation Framework and, for the period March 2025 to February 2026, there were 139 reported. In most instances these are because of poor availability of resources as a result of delays in transfers of care.

For the period April 2025 to March 2026 the Trust received 1,583 complaints. The majority of these related either to NEPTS and patient transport eligibility criteria or delays in response to 999 and NHS 111 Wales calls.

In March 2025 the Trust received two Public Service Ombudsman Wales Public Interest Reports, the recommendations of which have been accepted.

It is acknowledged as unacceptable that the Trust has not reached the required performance level for concerns for more than 18 months. A Trust recovery plan identified three key areas affecting performance and response times; high complaint volumes resulting from delays in attendance and application of the patient eligibility criteria for patient transport, complexity of investigations having increased as a result of changes to the 999 service model and availability of investigators.

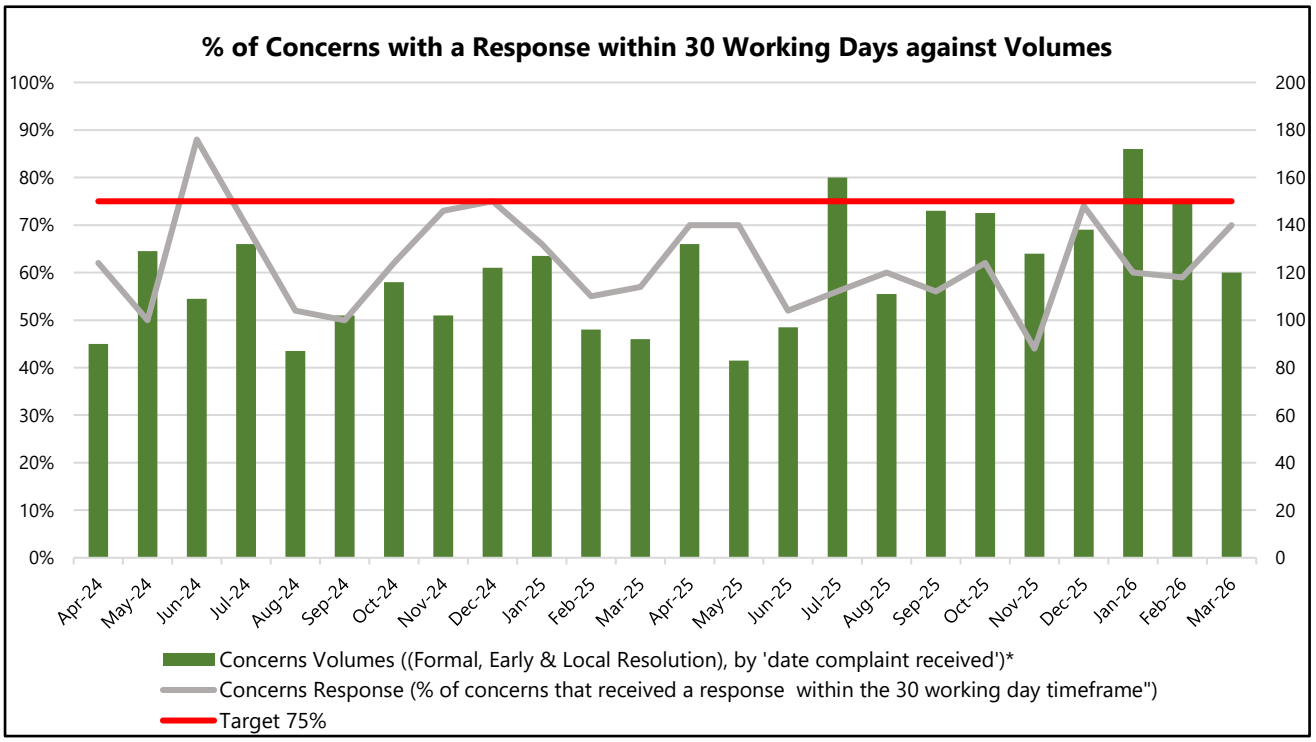
A further concern has been increased sickness absence within the Putting Things Right Team which has required enhanced support from the People and Culture Services team to secure wellbeing and support to colleagues working directly with the individuals and families /carers experiencing these delays.

Key actions being taken to improve performance have included:

- an increased financial allocation to operational teams and the release of senior clinicians from the clinical model transformation and ambulance performance framework implementation to increase investigation capacity

- working with patient transport services to improve call centre scripts and reduce the volume of formal complaints
- the establishment of a concerns management improvement programme board with close monitoring by the Executive Leadership Team, with oversight of improvements being regularly reported to the Quality, Patient Experience and Safety Committee and the board.

Critically for the 999 service, the complaint and incident volume and complexity are in large part driven by delays in responding to patients, either remotely or face to face, due to volume of calls being received or the availability of ambulance crews when they are experiencing delays in transfers of care to hospital colleagues.



Patient experience and quality improvement

Understanding patient experience and using that intelligence to inform services is of the utmost importance, particularly at this time of considerable change in the way services are delivered. Patient experience is included within the scope of recently commissioned academic evaluation of the refreshed clinical model and performance management framework, while the organisation's Patient Experience and Community Involvement (PECI) team continues to secure patient insight through a range of routes.

A recent key area of focus for the PECI and Information Governance teams this year has been securing Information Commissioner's Office approval to adopt SMS (texting) as a route to gaining patient feedback at a scale reflective of the service provided. The organisation has now approved a data privacy impact assessment for the use of SMS in 999 services and is in the final stages of completing one for 111. Work is underway to implement 999 SMS patient experience, and it is anticipated that this will offer significant improvement in the level of insight gained and the opportunity to review this alongside population health analytics to improve service delivery and better understand how WAST can play its part in targeting our approach to reducing health inequalities.

There has also been significant work undertaken to secure improvements in the experience of people using NEPTS. As a result of this work, the specification of newly commissioned patient transport vehicles has changed, and measures introduced to existing fleet that improve the experience of people living with dementia. Work has also been completed to support the NEPTS team working with patients requesting transport who do not meet the eligibility criteria that has reduced the number of complaints received, albeit they remain high – this is also linked to the work on reducing complaints.

Healthcare acquired infection

The Trust has recently reconfigured and recruited to the Infection, Prevention and Control team to secure appropriate specialist advice, including employing a pharmacist to lead on antimicrobial stewardship. Further to completion of a baseline assessment of our approach and the development of a local improvement plan, the team are currently reassessing the Trust position against the Welsh Government IPC Quality Statement and will also do this in line with the pending Code of Practice for Healthcare Acquired infection.
A key area of development over the last year has been the roll-out of powered air purifying respirators to all emergency ambulances and response cars to secure high standards of

respiratory protection for staff and patients in the event of attending a patient with a highly contagious infectious disease or the need to have universal protection in place to respond to a community infectious disease outbreak. The team are also working collaboratively with Public Health Wales and NHS partners to ensure the Trust contributes effectively to the Clostridium Difficile Learning Collaborative with a specific focus on decisions to convey and the associated conveyance actions.

Safeguarding

Safeguarding is integral to the Trust's public accountability and organisational culture. Through established governance arrangements, transparent reporting and active learning, the Trust assures itself that safeguarding responsibilities for both patients and the workforce are being met in line with national requirements and are embedded within our approach to continuous improvement.

The Safeguarding team work closely with the Public Health Wales National Safeguarding Service to secure active engagement with Local Safeguarding Boards and participate directly in Serious Case Reviews where the Trust has been an active Party. The number of Safeguarding Referrals by Trust staff has increased across Vulnerable Adults, Children and Young People over the last year. For Vulnerable Adults, this increase has primarily been driven by referral for care and support and for Children and Young People, this increase has been for individuals considered to be at risk.

DELIVERING IN PARTNERSHIP

As one of very few pan-Wales public bodies, the Trust has a multiplicity of stakeholders, which can make engagement complex and fragmented. The Trust has taken action to prioritise these key relationships given the benefits accrued.

System leadership and effective partnership working

The Trust is commissioned to provide its services by the JCC. The Trust's Chief Executive is invited to attend and participate in committee meetings, regular Director-level provider / JCC performance meetings have recently been established, and colleagues actively participate in the full range of service specific commissioning fora. Commissioners set commissioning intentions for the organisation each year which are reflected in the Trust's plans, with progress against these reported regularly throughout the year.

As a statutory organisation, the Trust participates in a range of system wide programmes: the Chief Executive and Executive Director of Strategy, Planning and Performance sit on the Six Goals Programme Board; the Chief Executive is a member of the newly established Community by Design Programme; and the Trust is represented at a senior level on the Integrated Community Care System National Leadership and Delivery Groups. These provide opportunities for the Trust to participate in and influence system-wide strategy and delivery.

The relationship with commissioners continues at a local level, with Trust colleagues actively contributing to a range of health board structures supporting urgent and emergency care. There has been a recognition that further time is required to develop strategic thinking in relation to the future vision for ambulance and 111 services, and consideration is being given within the JCC as to the most appropriate mechanisms to facilitate this in the future.

The Chief Executive is an active participant and member in the Chief Executive Management team meetings and NHS Leadership Board. As a Category 1 Responder according to Civil Contingencies Act, the Trust sustains its involvement across all four Local Resilience Forums in Wales, and also in other EPRR groups.

Stakeholder engagement and social partnership

While a decade ago the issues of reintegrating the Trust as a key player within the wider health and care system were acute, this is less the case now. The Trust has made good progress in being regarded by many stakeholders as an innovative system partner and, while there is no doubt some way to go, the organisation is in a very different place from where it found itself some 10 years-plus ago.

Over the past few years, the focus of the Trust's stakeholder engagement activity has been both on gaining support for, and understanding of, the evolution of its clinical model, together with an appreciation of the impact the Trust, as one of the very few pan-Wales NHS providers, can have on the wider NHS Wales system with the right level of collaboration. Involvement from the Trust Board was key to shaping this activity and for them to understand the feedback from stakeholders, including Llais, on the clinical model. Board members were able to speak directly to staff at Chief Executive roadshows, long service and other awards events as well as regular board 'walkabout' visits, to get a sense of the support for the model and its impact on staff and patients.

There has been a focus on gaining representation on, and contributing to statutory partnerships, particularly Regional Partnership Boards, which were originally conduits of Integrated Care Fund monies and more recently the Regional Investment Fund. The Trust has benefited from this in terms of both visibility with partners and funding, notably in support of falls and mental health response services. The Trust is now a member of all seven Regional Partnership Boards, holding the Vice-Chair in North Wales.

The Trust also works closely with a number of academic partners, not only in respect of training and education, but also in the research and innovation arena, which reflects the organisation's commitment to embedding university trust status, both in its contribution to research and developing innovation solutions to address challenges, as well as in adopting best practice in its delivery of services.

Supporting staff to pursue their development, whether that is through formal education or in developing their research and innovation ideas, remains central in optimising the benefits that university trust status signifies.

The Trust's relationship with other emergency services is also important, from both a response perspective but also in respect of strategic alliances which can be built upon to support delivery of services to patients. Similarly, the Trust has some strategic partnerships with third sector organisations, such as St John Ambulance Wales, supporting both operational delivery and presenting opportunity for broader collaboration.

For the first time in some years, the Trust Board has recently de-escalated its reputational risk (201), disaggregating the stakeholder and patient experience aspects of the original risk, to more accurately reflect the current position. However, it is recognised that where performance remains fragile and patient experience sub-optimal, the Trust's reputation remains at risk.

The core challenge now is to ensure that the Trust's approach to collaboration, partnership and engagement is focused specifically on a small number of issues which require an acute focus in order to deliver better outcomes for the organisation, its people and the population more broadly.

Given the Trust's existing objectives, its ambitious delivery intentions and its strategic challenges, these more tailored foci for engagement moving forward are likely to include:

- commercial partnerships (both to complement the Trust's commercialisation/financial sustainability agenda, as well as to look at where commercial partnerships may deliver solutions to specific challenges, for example in the digital field)
- academic partnerships (on the research and innovation front, as well as the learning and education and future workforce dimensions)
- public/third sector partnerships (for example, on specific aspects of delivery or infrastructure, and particularly in respect of enhanced engagement with health boards as both delivery partners and commissioners)
- engagement (stakeholder, public and patient) in relation to the Trust's long-term strategy

The Trust continues to invest significant time and energy in strengthening social partnership, delivering a positive impact on workforce engagement and culture. We have established a robust, multi-tiered structure for collaboration across the organisation, starting with Local Partnership Forums where Trade Union Partners (TUPs) and management teams address service-specific issues. This is complemented by the Corporate Partnership Forum, Operational Senior Leadership Team/TUP meetings, and leadership-level forums, all underpinned by governance arrangements. Our Welsh Ambulance Service Partnership Team is our main strategic level partnership forum that meets bi-monthly and reports into the board's People and Culture Committee.

In February 2025, two TUPs co-presented with colleagues from the People & Culture team at the Ambulance Leadership Conference, sharing the Trust's journey to "Walk in Each Other's Shoes", a first for the event. Building on this momentum, March 2025 saw the Trust host its inaugural Social Partnership Conference for managers and TUPs, featuring keynote addresses from the Minister for Culture, Skills and Social Partnership and Shavanah Taj, Trades Union Congress General Secretary. Plans are already underway for similar learning-focused events in 2026, aimed at frontline managers and TUPs.

TUPs play a vital role in Board and Committee meetings, operational task-and-finish groups, case work and project work, ensuring colleagues' voices are consistently represented. While debates and discussions are often robust and challenging, they remain respectful, professional, and constructive, reflecting the strength of our partnership approach.

The People and Culture Committee monitor our principal risk related to maintaining effective and strong TUP relationships at each meeting. Whilst the risk did increase in 2023 and 2024, it has remained at a score of 12 since November 2024.

The Trust is not blind to the residual risk of industrial action moving forward but believes that its much-strengthened TUP relationships will ensure that any action taken on national or, indeed, local issues can be managed effectively, as it was in 2022/23, notwithstanding that any action does pose a patient safety issue.

Pathways of care and broader system integration

The Trust is working collaboratively across the wider urgent and emergency care system to support increased delivery of care closer to home, enabling the rollout of Single Points of Access and implement the national Call Before Dispatch / Call Before Convey programme. These initiatives are designed to reduce unnecessary hospital conveyance and improve patient experience.

However, despite several years of partnership working, progress on community and Emergency Department alternative pathways has been inconsistent. There remains considerable variation across health board areas, particularly regarding acceptance criteria, operating hours and risk appetite. For alternative pathways to be effective in reducing Emergency Department attendances, system-wide consistency is essential. Acceptance criteria must be aligned to patient need, and pathways must be sufficiently robust to support patients with increasingly complex presentations.

It is hoped that greater collaboration with health boards in the forthcoming year, together with more opportunity for strategic discussion, through the JCC mechanisms, improved executive to executive interaction with health boards and participation in initiatives like Community By Design will see a step change in both the consistency and availability of community pathways across Wales, which will enable patients to flow more seamlessly to the most appropriate avenue of care.

Women's health plan

Women's health, particularly maternity and neonatal care, remains a critical priority for the Trust. Unplanned maternity and neonatal incidents in out-of-hospital settings present unique vulnerabilities, and the Trust has focused on ensuring timely, clinically appropriate decision-making across urgent and emergency care pathways to support staff and provide safe, compassionate care for women, babies and their families.

The Trust recognises the anxiety that pregnancy, particularly in its early stages, can bring for women and families. Continued focus is to ensure that anyone contacting NHS 111 Wales or 999 is treated with compassion and supported through care pathways that are clinically appropriate, emotionally responsive and tailored to individual need. The Trust is committed to working towards a system where women and families receive the right care, first time, through pathways that are clear, safe and responsive.

This commitment has driven strengthened leadership, governance and clinical focus over the last eighteen months to improve safety, consistency and system integration. The Trust has played an active role in promoting pre-hospital emergency and neonatal safety across Wales, working in partnership with health boards and national stakeholders.

This has included strengthening access to timely clinical advice for frontline teams and service users, improving escalation pathways to support rapid and safe transfer of women and babies when required, and embedding learning through timely and proportionate incident review. Targeted improvements have been delivered in pre-arrival instructions, clinical guidance and professional support for staff, alongside clearer interfaces between urgent care and maternity and neonatal services, contributing to improved equity and consistency of care.

Building on this foundation, the Trust is working with the Welsh Government chief Midwifery Officer to scope a National Maternity Line. This future programme, if commissioned, would improve access to specialist maternity advice, reduce variation in decision-making, and support safer care closer to home, with clear escalation routes for face-to-face or emergency care when clinically required. This approach reflects learning from incidents, reviews and service user feedback, and aligns with wider system efforts to strengthen maternity and neonatal safety.

The Trust also recognises the importance of a whole-pathway approach to women's health. Work aligned to perinatal mental health is being considered alongside maternity and neonatal care, recognising the interaction between mental health, safeguarding, access to services and outcomes for both parent and baby. This includes strengthening awareness, escalation and partnership working to ensure timely and appropriate support for those experiencing perinatal mental health needs.

Overcoming health inequalities

The Trust has worked with Public Health Wales to develop placement opportunities for Public Health Specialist Registrars (SpR). The first SpR was hosted in 2025 and led on several pieces of work including undertaking a baseline assessment of the Trust's approach to population and public health using an assessment tool that has been adopted by UK ambulance services. Recommendations from the SpR have been considered and will inform the evaluation of the Clinical Model Transformation and, how population health analysis is built into future reporting.

A key area of focus in recent months has been considering the development of insight into health determinants that influence the outcomes of patients in the Trust's care. Specifically, the integrated data services team that will secure output area-based analyses to identify possible factors, including deprivation, rurality and ethnicity.

STRENGTHENING THE ORGANISATION

The Trust takes the stability, efficiency and effectiveness of its organisation seriously. The sustainability of the organisation is one of the key tenets underpinning its wellbeing objectives, as required by the Wellbeing of Future Generations Act.

Wellbeing of Future Generations Act

The Trust has celebrated the first anniversary of its pledge to protect the wellbeing of future generations. The Trust's wellbeing objectives were published a year ago under the Wellbeing of Future Generations (Wales) Act 2015, which requires public bodies across Wales to work together to improve the long-term social, economic, environmental and cultural wellbeing of Wales.

The Trust has three wellbeing objectives focused on its role as an employer, a provider of care and as an anchor organisation committed to long-term sustainability. These objectives were developed with staff and Trade Union partners. Key achievements in the Trust's three priority areas over the past year include:

A socially responsible and inclusive employer:

- the Trust held its first social partnership conference to unite senior leaders, Trade Union partners and staff, with an opening address by Jack Sargeant MS, Minister for Culture, Skills and Social Partnership
- the volunteer cohort has grown to nearly 900, including Community First Responders, Community Welfare Responders and Volunteer Car Service Drivers, with several moving into full-time, paid roles as part of its 'Volunteer to Career' approach, providing opportunities for people across Wales
- the Trust pledged to become an Endometriosis Friendly Employer, support staff with the disease and tackle menstrual health taboos in the workplace.

An innovative and sustainable organisation:

- ten fully electric maxus vehicles joined the Trust's fleet, alongside 20 Ford Transit Custom plug-in hybrids thanks to a £22.4 million investment by Welsh Government in cleaner, greener vehicles
- the Trust is trialling drone-delivered defibrillators in partnership with the University of Warwick and SkyBound to explore if they could make a difference to someone in cardiac arrest
- NHS 111 Wales launched Albot, an AI-powered virtual assistant to provide faster, more seamless health advice online as part of broader improvements to the website
- the Trust's work to digitise patient records has been shortlisted for a HSJ Digital Award in the Outstanding Achievement in EPR Implementation and Optimisation category

A pro-active, accessible and equitable care provider:

- the Trust introduced new 999 call categories to ensure patients get the right care for their needs. The changes are in response to new performance measures by Welsh Government and the continued focus on patient outcomes, not solely on response times

- new specialist clinicians have been appointed to support paramedics and nurses in clinical contact centres to deliver remote consultations, enabling more patients to receive care closer to home
- the Trust is now the host organisation for Save a Life Cymru, a programme to promote early CPR and defibrillation and improve accessibility of defibrillators across Wales.

The Trust is building on these objectives within the 2026-29 IMTP. The Trust's 2026-29 IMTP was approved by the Trust Board on the 26 March 2026.

Corporate governance and risk management

The Trust has maintained strong corporate governance and financial control, evidenced by a positive Audit Wales Structured Assessment and by remaining at escalation level one. An independent Board effectiveness review has been commissioned to further strengthen strategic grip and capacity. The Trust has embedded a strong Board-level risk culture, with principal risks linked to strategic objectives and subject to regular oversights. The Trust is developing and embedding a strategic Board Assurance Framework (BAF) and risk appetite statements as part of the 2026/27 strategy refresh. More on these areas of governance are set out in more detail in Part 2 Accountability Report.

Financial position and sustainability

The Trust has a strong record of financial delivery, balancing its budget without the need of any external support for each of the last 10 years. This is underpinned by strong financial management and probity which is evidenced in a range of external evaluations, including the Audit Wales annual Structured Assessments, varying Internal Audit Reports and by having an unqualified opinion on its Annual Accounts.

The Trust developed an ambitious but achievable financial plan for 2025/26 as part of the IMTP, presenting a balanced financial plan but not without some inherent risks, including in relation to savings delivery assumptions. The financial plan was based on a set of key income assumptions along with an ambitious savings target of £8.5m (c3%).

The revenue financial performance at year end for 2025/26 was a surplus of £78k in line with the financial savings plans (£8.5m) that support the IMTP, gross savings of £8.555m was achieved during the year 2025/26, so a small overachievement of £0.055m. One further positive is the level of recurring savings that are now being delivered, which is increasing

year on year. Public Sector Payment Policy was on track with performance of 98.4% for the number, and 98.8% of the value of non-NHS invoices paid within 30 days (target 95%). The 2025/26 capital expenditure limit was set at £33.176m, and the same figure was spent during the year.

Further information can be found in the financial statements in Part 3, which have been prepared on a going concern basis. It is noted that in year Technical Update four issued by Welsh Government on the 5 December 2025 in relation to '2025-26 Discount rates for general provisions, post-employment benefits, financial instruments and leases (under IFRS 16): announcement of rates' was applicable to the Trust.

The Financial Sustainability Programme established in May 2022, was created to deliver financial sustainability, assurance, and oversight to enable the delivery of IMTP objectives. Since its inception, the programme has focused on achieving savings and efficiencies while also identifying opportunities to generate new income. Going forward, it will monitor saving plans and delivery and will consider the outcome of the JCC service review and benchmarking to transform services to be effective, helping plan for future financial years. In January 2024, Akeso Consultancy was engaged to undertake market analysis of commercial opportunities, and by March 2024, the findings were presented to the board.

The recommendations were accepted, and funding was approved to recruit a Head of Commercial Development, who commenced their role in October 2025. Through a dedicated Commercial Steering Committee, the Trust will seek to build trusted and innovative commercial partnerships, create sustainable value, and enable reinvestment in patient care and community wellbeing across Wales. The first 12 months will be spent building capacity with income targets then to be identified for 2027/28 and beyond.

Recent developments have maintained a strong focus on both cost efficiencies and income generation. All 24 recommendations from the 2023 Administrative and Support Review have been implemented or embedded within directorate plans, and the review has been formally closed with endorsement from the FSP Governance Group.

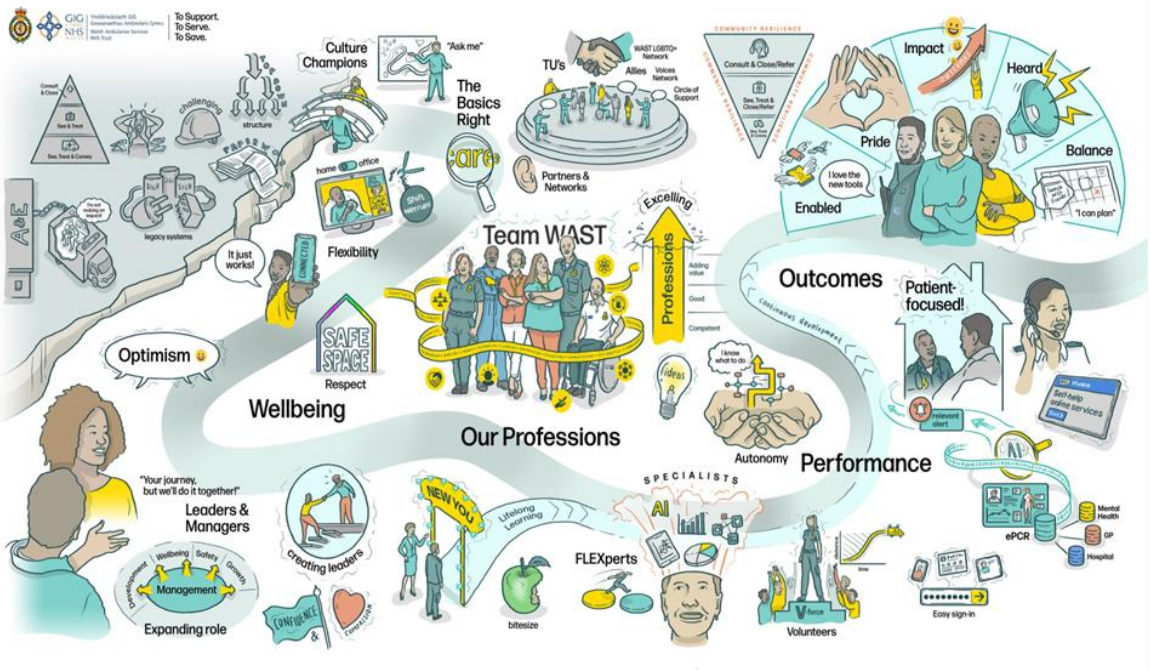
Additionally, a comprehensive organisation-wide Service Review was completed in 2023, engaging more than 50 service areas and generating more than 330 improvement proposals. These recommendations have been structured into four tiers of implementation, supported by governance mechanisms to ensure prioritisation, accountability, and benefits

realisation. A review is currently underway to measure progress against the actions. To strengthen this work, a Project Opportunities Group will soon be established to identify, scope, and assess opportunities for cash-releasing savings, spend avoidance, and additional income generation.

Looking ahead, the next steps include drafting the Commercial Development Plan and finalising Service Review actions by January 2026, holding the inaugural meeting of the Financial Sustainability Programme Commercial Development Group in January 2026, launching the Project Opportunities Group in February 2026, and publishing the Commercial Development Plan in March 2026.

Culture and workforce

The organisation's People and Culture Plan reflects the Trust's ambition to create a positive, inclusive, and high-performing culture where colleagues feel valued and supported.



To measure progress, key indicators are reviewed that demonstrate the impact of the plan. The latest data (December 2025) highlights the following outcomes, with some further detail provided in following sections of this evidence pack:

Metric	As at March 2026	Trend	Commentary
People Networks	Membership at more than 1,000 across 10 networks	⟷	Almost a quarter of the workforce is now engaged with the Trust's People Networks. Ten People Networks are in operation to support colleagues who have lived experience or are allies to people who may face disadvantage or discrimination. Having seen the benefits of current networks, this year there has been an appetite to establish a new Welsh Language and Culture Network and a new Veterans Network. A review of the Trust's People Networks is planned for 2026 with the introduction of Executive Sponsors for each network to strengthen the relationship between the networks and the Trust Board to help influence change and improve decision making.
Disciplinary cases	46 open cases	⟷	Consistent with other reporting periods
Formal request for resolution	13 requests	⟷	Consistent with other reporting periods
Turnover	7.75%	⟷	Consistent, indicating improved retention and job satisfaction linked to Our WAST Way and wellbeing initiatives.
Absence (rolling 12 month)	7.92%	⟷	Consistent with previous periods
Absence (in month)	7.47%	↓	Slight downward trend over three months but remains above the planned abstraction rate and is therefore affecting our ability to fully deploy resources. However, this mirrors seasonal pressures (Flu/RSV), with examples of several

Metric	As at March 2026	Trend	Commentary
			health boards and WAST (in some circumstances) already mandating mask wearing to minimise further staff infection. From February 2026 the Occupational Health & Wellbeing Team have moved into the People Services Team which will result in a multi-disciplinary team approach to holistic absence support to managers and employees.
Statutory and mandatory training	91.62%	↑	Slight increase from previous return and remains above Welsh Government target of 85%, reinforcing commitment to learning and regulatory compliance.
PADR (see below)	76.65%	↑	Consistent with previous periods, highlighting need for stronger embedding of performance and development conversations. Slight upward trend but remains below WG 85% target.

Organisational culture

The Trust has worked hard for a number of years to improve its leadership and culture while consolidating its governance to ensure rigour, grip and continuity. One particular facet in which considerable time and resource has been invested is in creating a sexually safe and inclusive culture, where colleagues feel able to speak up. This has led to the Trust becoming a sector-leading organisation in the realm of organisational cultural change.

The Trust has made notable progress in delivering Strategic Equality Plan (SEP) objectives. Workforce diversity has improved, with increases in representation among ethnic minority staff, colleagues with disabilities, LGBTQ+ communities and Welsh speakers. The gender pay gap has reduced to 5.3%, and early analysis of the Workforce Race Equality Standard (WRES) indicates positive changes in the experiences of ethnic minority staff and widening of representation. Gender balance remains strong with women now accounting for 55.6% of the workforce. These achievements have been supported by initiatives focused on

leadership and culture, inclusive recruitment campaigns, and improved access to interpretation and translation services, including British Sign Language.

Despite these achievements, challenges remain, particularly around competing priorities and resource constraints, which can limit engagement with SEP initiatives. Current workforce demographics also present barriers to fully realising the Trust's ambition of becoming a truly inclusive employer and service provider.

The Trust is strengthening its approach to reviewing and shaping culture across the organisation through a structured, evidence-based organisational development process called the "Working Well Together" framework, underpinned by the Cultural Early Warning Score (CEWS) tool. CEWS has been developed in- house and acts as a supportive, interactive guide for managers and teams to collaboratively assess their team culture, addressing key indicators such as engagement, relationship dynamics, change, wellbeing, behavioural concerns, attendance, and other key people metrics. It is now being shared with a number of NHS organisations across Wales to facilitate proactive assessment and tracking of cultural change improvement. The impact of the tool and associated support has been positive when adopted in specific areas of the business and this evidence-based approach of achieving sustainable cultural change at a local level has been welcomed and shared wider. Pilot feedback has shown that using CEWS created space for open, honest conversations, exploring themes or reasons impacting their culture that teams may not have previously had, strengthening shared understanding, increasing buy-in and enabling staff to actively contribute to identifying and addressing cultural concerns and feeling their voice has been heard.

Speaking Up Safely remains an ongoing commitment for the Trust, creating a culture where staff feel empowered to raise concerns safely and confidently. The Speaking Up Safely Annual Report for the period 1 July 2024 to 30 June 2025 shows that 113 concerns were raised, with 56% submitted directly to the Guardian and 44% via the Work in Confidence platform. The NWSSP audit awarded a reasonable assurance rating, reflecting robust governance and processes.

Welsh language

The Trust values and respects our Welsh speaking staff, service users and stakeholders, actively supporting the recruitment, retention, and development of Welsh speakers across the organisation. Delivering bilingual services is fundamental to providing safe, equitable and person-centre care, particularly for those priority groups identified in Mwy na Geiriau / More Than Just Words.

The Trust's Welsh Language Framework, which incorporates the More Than Just Words Action Plan 2022-2027, sets out the Trust's aims and objectives to increase the visibility, accessibility, and everyday day use of Welsh and opportunities for the Welsh language. It also outlines targets to enhance support for Welsh-speaking communities and for our Welsh learners who are developing their language skills.

Strong leadership plays a vital role in advancing this agenda. The board promotes the Welsh language through visible leadership, clear governance arrangements, and integration within strategic planning. It is for this reason that the 'Active Offer' sits alongside the Strategic Equality Plan and takes account of the wider equality, diversity and inclusion work, and the People and Culture Plan with oversight of that plan, and the Welsh Language Standards Annual Report by the board.

Service delivery standards (correspondence and telephone calls) have improved with the introduction of an in-house translation service, as has the ability to quickly translate correspondence, communication platforms and publications more widely and aligning to standards. There is more work to do however on reception services as the first port of call for Welsh speakers.

Policy making standards have improved markedly over the last two years with the introduction of a Welsh Language Policy and integration into the Trust's policy process and has recently been held out by Internal Audit as a substantial assurance objective. An impact assessment for Welsh language features for each Trust policy.

Operational standards compliance (i.e. the use of Welsh internally) is growing stronger each year, with a significant increase in the number of resources available to staff both internally and centrally. 95.96% of staff have self-assessed and recorded their Welsh language skills on the Electronic Staff Record (ESR) system. Staff who assess at level 0 are encouraged to progress to level 1 as they complete Welsh language courses.

There has been a steady increase in the number of service users accessing Welsh language services when calling NHS 111 Wales and NEPTS. Service users are welcomed with a bilingual greeting, followed by our Integrated Voice Response (IVR) system that allows callers to select their preferred language being Welsh or English. During 2023/24 the NHS 111 Wales Service saw a significant increase in performance on Welsh language call answering rising from 18% in 2022/23 to 45%. In 2024/25, performance remained stable at 45.7%. An improvement plan is in place, including targeted recruitment, weekend call handler profiling, and opt-out flexibility for callers. During 2024/25 NEPTS performance on Welsh language call answering was at 77%. A plan is in place to prioritise recruitment of Welsh speakers and align with the broader workforce strategy for 2026/27.

In 2026/27 the Trust will develop its five-year clinical consultation plan aligned to Standard 110. We have worked in partnership with the Welsh Language Commissioner's Office in 2025/26 with a focus on remote clinical care to support a sustainable increase in bilingual service provision.

Welsh speaking investigating officers are now in place should staff wish to have their complaints and disciplinary procedures conducted in Welsh. The intranet Welsh language page has an increasing number of resources for staff with training sessions provided to senior leaders for increasing confidence in the use of Welsh language when conducting meetings. Since the introduction of the mandatory Welsh language awareness course on 1 April 2023, 78% of staff have completed the course. The course is promoted as part of the WAST Welcome Days for new staff and during the promotion of Welsh cultural events.
A new Welsh language beginners' course for EMS staff developed in partnership with the National Centre for Learning Welsh. The course which is tutor led on Teams is tailor-made for staff who want to be able to engage with our Welsh speaking patients at that first point of contact.

Record keeping standards shows good upholding of standards, with 1 complaint being received related to Welsh language in 2025/26. A 2025/26 internal audit on Welsh language returned a reasonable assurance rating on our arrangements to embed Welsh language at the Trust.

Staff engagement

Staff engagement is critical to organisational culture and performance. The 2025 NHS Wales Staff Survey response rate was 43.2%, a continued rise from 35.2% in 2024 and 23.2%

in 2023. This upward trend reflects growing colleague participation and confidence that feedback is being acted upon.

Over the past year, approaches to engagement have been strengthened by:

- building behaviourally informed communication
- closing feedback loops and demonstrating visible impact
- introducing quarterly pulse surveys aligned to Our WAST Way to explore emerging themes and support continuous improvement
- providing directorate-level data to enable targeted local action plans

Pulse surveys will continue to help directorates test the effectiveness of actions and make timely adjustments. Once final survey results are available in quarter 4, the Trust will:

- publish an infographic-style organisational overview
- share detailed analysis with the board, executive team, and Trade Union Partners
- identify priority themes to shape next year's pulse survey cycle and wider engagement activity

A comprehensive board to frontline programme is actively maintained, fostering engagement and transparency throughout the workforce. Promoted through a variety of channels such as ELT road shows, Non-Executive Director (NED) visits, WAST Live sessions, blogs, and vlogs. These ongoing activities ensure strong visibility and direct communication between the board and staff across all levels of the organisation.

The Trust is increasingly concerned about the effect the current work environment is having on our staff, as many have reported feeling exhausted and frustrated, alongside a rise in incidents of abuse from patients and the public. Although issues such as burnout and fatigue have been highlighted before through the staff survey, for example, it is evident that these challenges continue to significantly affect our people's personal lives. For this reason, Health and Wellbeing is a priority, offering practical tools and resources to help both colleagues and managers recognise early signs of stress and burnout, facilitate meaningful wellbeing discussions, and make reasonable adjustments for those with long-term health conditions. More detail is provided in the section below.

Alongside this the Trust has recognised that the level of change within the organisation has been significant. The change approach reflects our commitment to valuing our people, recognising the direct link between colleague experience and patient experience. Poorly managed change increases pressure, uncertainty and burnout but done well, it supports

confidence, wellbeing and sustainable performance. Effective change management is being embedded so that supporting people through change is simply how things are done and not an optional extra.

Rather than relying on a small group of specialists, capability is being built throughout the organisation, equipping leaders and teams to lead and support change locally. These skills and behaviours are embedded within leadership and management framework (Our WAST Way), reinforced through a growing Change Community and supported by a bespoke, practical toolkit. Overall, this approach keeps change simple and accessible, aligned with continuous improvement and project delivery, ensuring change feels inclusive, supportive and sustainable

In line with the ambition to be an employer of choice and to enhance the overall employee experience and following the flexible working coaching sessions delivered to the Operations Directorate, between August 2024 and December 2025, a total of 460 flexible working requests were submitted. Of these, 258 have been approved, 9 declined, and 193 remain in progress. together, these steps are building a more open, responsive, and sustained dialogue with colleagues about their experience at work.

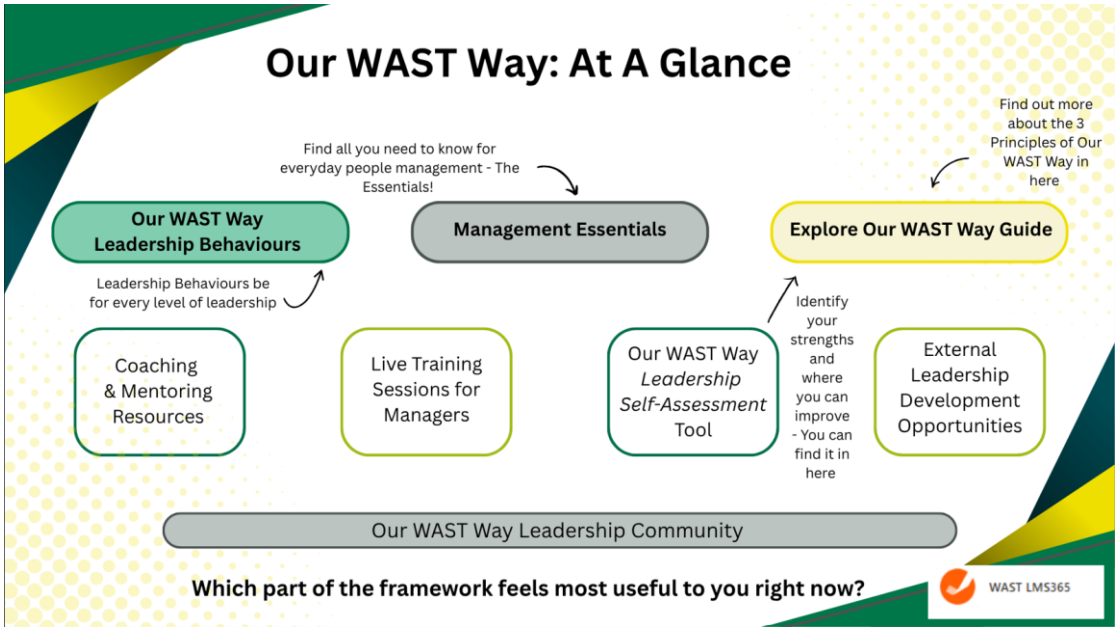
Leadership development

The Trust launched its new leadership and management framework, *Our WAST Way*, in May 2025, built on the principles of Care, Connect, and Value Everyone. It reflects both national leadership standards and what Trust staff have said matters most. Phase One focused on embedding the framework by introducing practical tools to support everyday leadership.



In-year delivery has already shown positive traction. More than 280 colleagues have completed the interactive brochure and self-assessment tool, over 130 have accessed Management Essentials, and over 500 attendances on live learning through Our WAST Way Applied and Essential Conversations. Alongside this, the Leadership Community has now grown to almost 400 colleagues, demonstrating clear appetite for shared learning and connection. This level of meaningful take-up shows the framework is resonating with colleagues and is already helping to build more confident conversations, more consistent leadership practice, and a more connected culture.

The programme is now progressing to phase two, which will focus on aligning formal learning programmes with the framework and strengthening coaching and mentoring capability across leadership levels.



This leadership succession planning approach focuses on strengthening leadership capability at every level. While formal development programmes remain important and future leaders are continued to be supported through national initiatives such as the Aspiring Director of Operations programme for the ambulance sector, as well as programmes delivered by HEIW, NHS Leadership Academy and Academi Wales, the Trust is also prioritising the connections that make leadership effective. This includes building positive relationships and alignment across the organisation.

Recent work has focused on the ELT, its direct reports, and the wider senior leadership community, including the board, all aligned to Our WAST Way principles. Workshops and engagement sessions have been delivered for senior leaders, focusing on collaboration, trust, and cross-functional working. These sessions have strengthened connections across the senior leadership community, helping to build a united leadership community. This provides individuals with exposure to different approaches, areas of work, and opportunities, which will be vital in developing future talent.

The ability of leaders to have effective and meaningful conversations with their staff is critical to improving well-being and resilience. While Performance Appraisal and Development Review (PADR) completion rates remain below the Welsh Government target of 85%, it is important to ensure that PADRs are meaningful conversations that support development and engagement, rather than being seen purely as a compliance exercise. The organisation's focus is therefore on transforming PADR into a process that genuinely adds value. This work sits within the wider Essential Conversations initiative, which aims to build managers' confidence and capability to have regular, informal conversations with their teams. By embedding routine one-to-one 'check-ins' throughout the year, PADRs will be supported by ongoing dialogue, making the annual review more relevant and impactful. As the new PADR process is designed, socialised and finalised, a pilot is planned for quarter 1 2026/27 with wider organisational roll out planned for quarter 3 2026/27.

In relation to the ongoing development of clinical leadership, the changes to the clinical model and the ambulance performance framework increase the importance of effective clinical leadership to ensure improved performance, safety and outcomes.

One example is the development of clinical navigators. These are senior nurses and paramedics who provide real-time clinical oversight within Emergency Medical Services Coordination Centres and, as set out in section 2 above, play a vital role in critical tasks such as high-acuity call reviews, queue safety assessments, and remote clinical support for frontline crews. By embedding clinical leadership into coordination environments, upfront in the call taking process is just one way the Trust ensures that patient care decisions are guided by experienced clinicians, improving safety and efficiency across the system.

In addition, the clinical model transformation programme is driving structural changes to enhance leadership, performance and accountability. This includes implementing our response to the new performance framework, digitising processes to ensure thorough understanding of how our patients flow through the model.

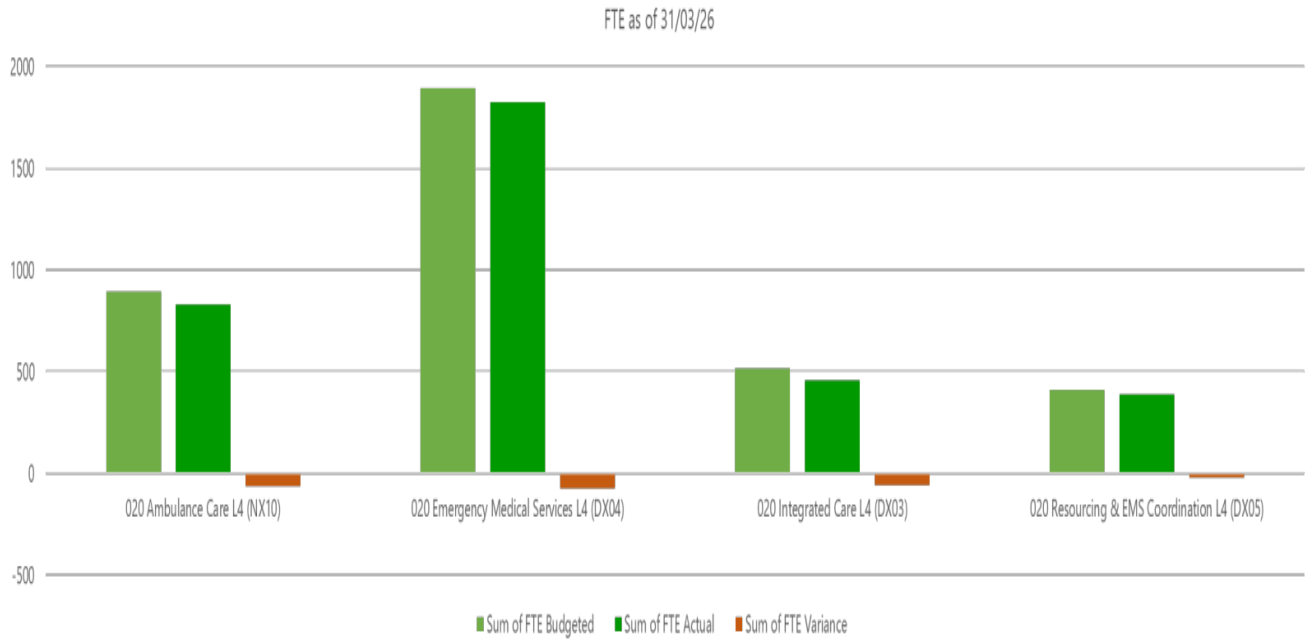
We also see future investment across our clinical workforce to enhance the provision of frontline clinical leadership, with senior clinicians overseeing the development and growth of our workforce, aligning their objectives to our clinical model and, through this, the outcomes within the ambulance performance framework.

All these developments go hand in hand with the education provision to our current and future clinicians. Support from HEIW in areas of work, such as with APPs, has been instrumental in shaping our service provision to be more in line with the evolving patient needs. Education and professional development are central to this strategy. Recent initiatives have addressed gaps in clinical confidence and competence, such as standardising electrocardiogram interpretation training and rolling out AI-assisted diagnostic tools. These programmes not only improve patient outcomes but also empower clinicians to take on leadership roles by equipping them with advanced skills and knowledge. The Trust's commitment to structured continuous professional development and collaboration with universities underscores its long-term vision for sustainable clinical leadership.

Integrating leadership succession planning into Our WAST Way, including mentoring and coaching across leadership levels, will take place starting from 2026/27.

Workforce sustainability

Staff recruitment activity remains a key priority across the Trust to ensure that the right number of staff are in post to deliver services. The visual below shows the vacancy levels in front line services.



In collaboration with the Digital Services Directorate, implemented targeted recruitment and application support initiatives within local Black Asian Minority Ethnic communities have enhanced ethnic diversity across the organisation and its functions.

To address workforce challenges in rural areas, a dedicated Rural Recruitment Task and Finish Group has been established. This looks at creating opportunities for localised recruitment, supporting employment and career progression within rural Welsh communities, and improving retention and stability of the Emergency Ambulance workforce in these regions. The Group has enabled the Trust to identify the main barriers to rural recruitment and to focus actions on these areas, including greater interaction between Workforce Planning, Recruitment and local management teams to specifically target local communities. Within South Gwynedd and North Powys local adverts gauge interest before undertaking engagement with these potential candidates, providing support to help them achieve the required employment pre-requisites for successful selection.

Additionally, a new Recruitment Strategy is currently in development. This strategy will emphasise standardisation and centralisation of recruitment processes across the Trust, inclusive recruitment practices to ensure equity and diversity and strategic attraction and workforce planning to meet future organisational needs. The initial scoping of the strategy is currently underway, with stakeholder engagement due to commence shortly. The aim is for the three-year strategy to be approved and published in quarter 4 26/27, followed by

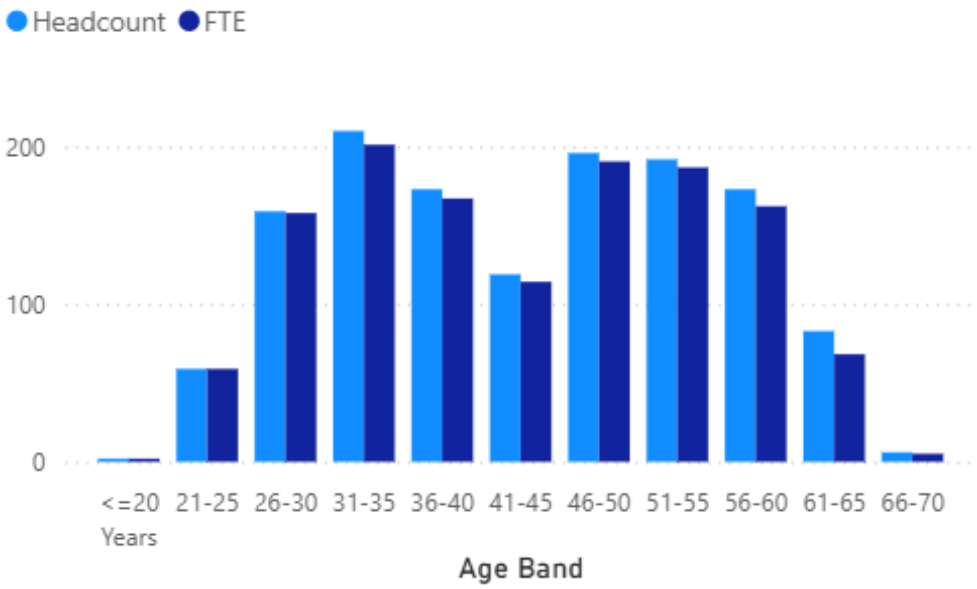
implementation of short-term actions over the following 12 months, and long-term actions across 2028/29 and 2029/30.

The HEIW-funded Retention Lead is approaching the end of a two-year tenure, during which time significant initiatives have been delivered to strengthen staff retention. Key achievements include the design and launch of a Health and Wellbeing Passport and accompanying Manager's Guide, enabling supported conversations and providing clear guidance on reasonable adjustments for colleagues with disabilities.

To enhance onboarding and retention, the Warm WAST Welcome Corporate Digital Handbook has been introduced that brings together essential information on corporate support offers, key policies, people networks, and more, helping new colleagues feel connected, supported, and a sense of belonging from day one.

Retention challenges remain in specific areas, notably among call handlers, where turnover is higher. However, a significant proportion of this movement reflects internal progression into Emergency Medical Service and NEPTS roles, demonstrating positive career development opportunities within the organisation.

Future workforce plans must consider the current age profile of the Emergency Ambulance workforce (including Emergency Medical Technicians (EMT), EAPS, and Paramedic roles), which reflects a broad distribution across age bands. While there is limited visibility of future retirements, historical retirement data across specific roles has been extrapolated to forecast upcoming retirements. The planned retirements within the 56–60 and 61–65 age bands over the coming years will support the reduction of EAP and Paramedic full-time equivalents required to achieve the new emergency ambulance skills mix, which will be achieved over a number of years.



Wellbeing

Within the last 12 months, the Trust launched its Health and Wellbeing Plan, reinforcing a commitment to staff and volunteer wellbeing through a proactive and comprehensive approach. Key developments include enhanced data reporting for assessment and monitoring, and the relaunch of the trauma risk management (TRiM) network to provide peer-based trauma support, supported by ongoing training and expansion of the responder network.

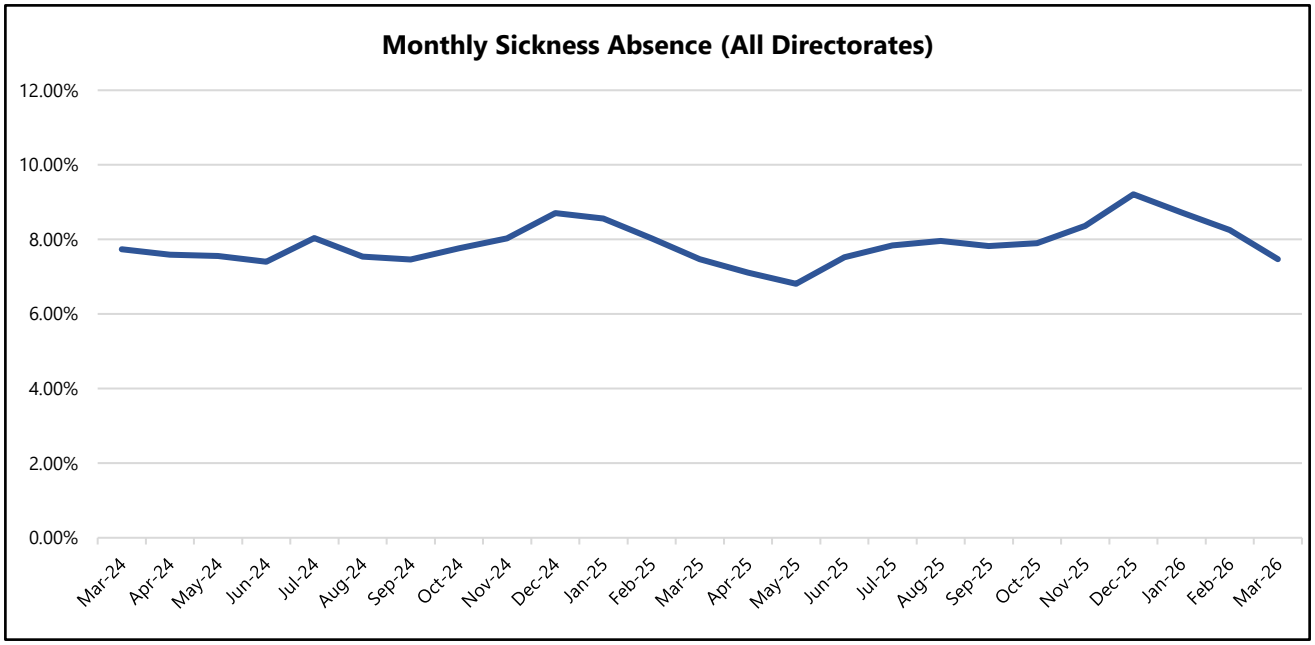
Since its relaunch, the TRiM network has grown to 37 trained responders across the organisation. Demand has increased steadily month on month, reflecting greater organisational awareness and improved confidence in accessing trauma support. Referral volumes rose from 37 at launch in September 2025 to 57 in November, 81 in December, and 65 in January 2026. This upward trend highlights both positive engagement with TRiM and the increasing operational need for timely trauma support. It also underscores the importance of further expanding the responder network to ensure workload is managed safely and sustainably, protecting responders from fatigue and reducing the risk of secondary or vicarious trauma arising from frequent exposure to challenging conversations. Suicide risk training has been integrated within the Wellbeing Team, and a formal suicide risk assessment process is now embedded into our contact structure to address known workforce risk factors. All Occupational Health and Wellbeing staff have completed suicide risk training, and a structured assessment tool is now routinely and consistently applied.

The Employee Assistance Programme (Health Assured) continues to offer confidential counselling, lifestyle and financial advice, alongside physiotherapy referrals and signposting to external agencies, including the TASC (The Ambulance Staff Charity) crisis line where appropriate. EAP usage between February 2025 and January 2026 showed clear peaks in August–October, aligning with wider organisational pressures. Anxiety and low mood were the most common presenting issues, consistent with key drivers of sickness absence across the Trust. More than half of users (57%) chose not to disclose their work area, emphasising the need for strong confidentiality, while those who did disclose were most commonly from clinical contact centres (999/111). Outcomes remain highly positive: 96.7% of individuals in work at the start of therapy stayed in work, and 47.6% of those off work returned by the end of their intervention. This reinforces the EAP's important role in supporting psychological resilience, sustaining work attendance, and improving return-to-work outcomes following mental health–related absence.

Promotional activity has been refreshed across the organisation to raise awareness of available support, and wellbeing drop-ins remain accessible at contact centres, stations, and remote locations on a rotational basis. Looking ahead, bespoke workshops on Workplace Stress and Sleep Management will launch early in 2026, supported by continued engagement and partnership working to ensure timely, comprehensive, and confidential wellbeing support for all staff.

Attendance/sickness

In March 2022, WAST introduced a structured project management approach to sickness absence with seven workstreams identifying proactive and reactive actions and activities to target absence across the organisation. As a result, absence has reduced from a peak of nearly 12.5% in December 2021 to 9.18% in December 2025 with the lowest organisational absence in May 2025 at 6.81%. However, it is important to note that EMS is 7.87% in December 2025 which is positive considering the ongoing system and environmental challenges experienced by our frontline crews. The pattern of absence follows the same trend lines year on year with peaks in December/January, July/August and smaller peak around March. This year early flu/colds/Covid are impacting the team directly. Trust-wide long-term sickness is currently 6.24%, short term is 2.94%.



A concerted effort by the People Services team supporting operational managers to handle sickness absence cases, manage within the policy framework, increase awareness, improving wellbeing and support as well as training delivery and coaching and mentoring for managers is helping to reduce the figures and efforts continue to further reduce the percentage absence. To support this, the Trust continues to embed a more modern, proactive, and person-centred approach to attendance management. Actions include:

- further embedding compassionate, trauma informed and psychologically safe management practices, ensuring that organisational processes minimise harm and support colleagues' wellbeing

- expanding flexible, personalised work options, including temporary, permanent, and agile working arrangements informed by individual circumstances, to help colleagues remain in work and sustain their employment wherever possible
- using enhanced data and analytics to identify trends, hotspots, and early indicators of wellbeing concerns, enabling more proactive and preventative interventions, including focused deep dives and target action to address root problems
- strengthening health, wellbeing, and early support pathways, including improved signposting, easier access to Occupational Health, Employee Assistance Programmes, and peer support networks
- embedding holistic return to work pathways, with structured support plans, phased returns, wellbeing conversations, and reasonable adjustments tailored to role and condition
- a strategic focus in reducing the number and duration of overrun occurrences within operations. This is balanced by an increase of approval of Time Off In Lieu (TOIL) requests, overall demonstrating a positive impact on colleague health and wellbeing.
- maintaining regular reporting to the Executive Leadership Team, People & Culture Committee and Trust Board, supported by deep dives into specific issues for improved oversight, assurance, and governance
- delivering innovative cultural improvement and employee experience initiatives, with a focus on psychological safety, inclusion, and strengthening team level wellbeing, recognising the strong link between culture, engagement, and reduced absence
- continuing partnership working with trade union partners to address attendance impacting issues such as handover delays, fatigue, workload pressures, and the timely taking of TOIL
- providing robust change management support, ensuring colleagues affected by transformation and restructuring are well supported through clear communication, involvement, and fair processes
- ensuring proactive People Services engagement, including case reviews with senior managers for visibility, consistency, accountability, and the early identification of support needs
- introducing modern managerial capability development, including training in supportive conversations, mental health literacy, and managing complex or long-term health conditions with empathy and confidence.

Sickness absence in the Trust is average for the ambulance sector and caution should be exercised when compared to health board figures because of the different risks of infection and injury in different settings. The sector is high risk for post-traumatic stress disorder (PTSD), mental health and suicide because of the trauma and stress of the role. For example:

- a recent systematic review found that among EMS clinicians (paramedics, ambulance staff, pre-hospital emergency providers), the proportion of deaths due to suicide was 5.2%, more than twice the 2.2% in the general population
- a sector-wide survey of EMS workers suggests very high mental-health burden: many report depression, anxiety, PTSD and "serious suicidal ideation"
- according to data collated by the UK's Association of Ambulance Chief Executives (AACE): male paramedics were quantified as 75% more likely to die by suicide than the national (working) average, i.e. significantly elevated compared with many other jobs

Therefore, it is unsurprising that the primary reason for sickness absence is mental health (3.03%% in December 25), followed by coughs/cold/flu (0.82%) gastro (0.82%), MSK (musculoskeletal) (0.81%), injury/fracture (0.46%) and back problems (0.45%). As noted above, when there is a seasonal surge in infections e.g. colds, flu, RSV (respiratory syncytial virus), this also affects the team directly. Our mental health support offer is covered in the wellbeing section above.

Shift overruns

In previous IMTPs, the Trust has given a commitment to addressing the level of shift overruns within the EMS service, it is known that this is cause of stress and could be a contributor to higher than desired absence levels. In December 2024 there were nearly 3000 shift overruns, with an average overrun time of 41 minutes. In December 2025 this had reduced to around 2400 overruns with an average overrun time of 35 minutes. Whilst this represents some progress in terms of volume and length, the Trust wants to go further. The Trust has implemented a comprehensive, multi-disciplinary approach to tackling operational overruns, prioritising patient care, staff wellbeing, and organisational efficiency. This work is driven by structured governance, regular review meetings, and continuous data analysis, ensuring clear ownership and accountability for every action.

TOIL (time off in lieu)

TOIL remains a high-profile issue in discussions with Trade Union Partners, particularly in relation to staff wellbeing, service delivery, and the risk of industrial action.
The current Resourcing Policy (2014), identified for review through internal audit, is scheduled for update in the coming months. Differing interpretations of the policy have led to disputes, especially regarding staff entitlement to TOIL accrued from mandatory overruns. Notably, more than 60% of TOIL is generated from unplanned extensions to contractual hours, with staff and unions seeking greater flexibility in when TOIL can be taken. It is becoming evident that improvement to hospital handover may not have the direct equivalent impact on reducing overruns.

To address these challenges, a new TOIL process was launched on 15 September 2025, designed to increase flexibility and deliver an additional 11,500 hours per year beyond current approvals. A six-month pilot, starting with EMS, is underway with monthly partnership meetings to review outcomes and ensure consistency in decision-making. Outcomes of the pilot will be monitored through monthly reviews of approvals, declines, staff feedback, and impact on sickness/abstraction rates, and develop a clear position on operational and wellbeing impacts, supported by data on abstraction rates. Early monitored outcomes indicate a positive position with up to 95% of all submitted TOIL approved.

Workforce skill-mix and sustainability

Work continues to support the upskilling of former Band 4 EMT colleagues into Band 5 EAP roles, with all training scheduled for completion by Summer 2026.The desired emergency ambulance skills mix, as agreed by the ELT, was communicated to the organisation in early January 2026. Efforts are underway to align workforce establishment at Band 4 EMT, Band 5 EAP, and Band 6 Paramedic levels in line with this skills mix. However, achieving this balance will require a significant period because of current turnover and progression trends.

With improved retention rates, low vacancy levels within Paramedic roles, and the need to realign the EMS establishment, there is a significantly decreased requirement for newly qualified paramedics (NQPs) within the Trust. Options to accelerate the realignment of EMS roles are being actively explored by the Senior and ELT, who will confirm NQP recruitment numbers for the next intake in early 2026.

The Trust is also committed to increasing urgent care provision with the growth of APPs, ensuring the workforce is more aligned to patient need and strategic direction. Whilst opportunities to grow our APP workforce remain strong, the ELT remains mindful of the current financial envelope, our responsibility to ensure fiscal sustainability and the need to optimise productivity of the current APP cohort.

Agency costs against the total pay figure remains very small and is set out in the staff report in part 2 of this annual report. This is to cover a small number of vacancies, in areas across the Trust which the Trust is having difficulties recruiting into including clinical, digital, fleet and estates. However, it is hoped that some of these agency staff will be replaced by permanent staff in the near future.

Given the uncertainty that remains around some information and communication technology (ICT) funding that has been received on a non-recurrent basis, the Trust continues to utilise agency staff in these roles to deliver the service, which it believes is appropriate given the inability to recruit on a substantive basis.

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.

DIGITAL, INNOVATION AND INFRASTRUCTURE

The Trust continues to invest in digital, innovation and infrastructure as key enablers of safe, resilient and sustainable services, with activity strongly aligned to national priorities. This work is supporting service improvement, future readiness and improved access for patients, while strengthening the organisation's operational foundations.

Realising the potential of digital and innovation

The Trust continues to deliver a maturing and ambitious digital and innovation portfolio that is directly improving operational readiness, patient experience, access to care and the overall resilience of our services. Our programmes demonstrate integrity of delivery, strong governance, tangible operational impact and clear alignment with Welsh Government priorities for a digitally enabled and future-ready NHS Wales.

Digital and innovation at the Trust are focused on one clear purpose: improving patient outcomes, staff safety and service resilience at scale. This approach prioritises safe delivery, operational impact and value for public money, moving beyond pilots into embedded, measurable change across urgent and emergency care. The Digital Plan 2024–2029 sets this out over five pillars that underpin our transformation and culture of innovation:

- everyday essentials – ensuring staff have the tools and skills to deliver care confidently and efficiently
- security, safety and cyber – safeguarding systems and data to maintain trust and resilience
- digital pioneers – empowering frontline teams to lead innovation and experimentation
- digital transformation – redesigning pathways and services to improve patient experience and operational efficiency
- data, information and insight – leveraging analytics and AI for better decisions and forecasting

These pillars guide an approach to embedding digital into everyday practice, supporting staff capability, and driving measurable improvements in care and outcomes. Progress against each pillar is reported to the Finance & Performance Committee who provide assurance to the board. In line with the Cabinet Secretary's guidance, the Trust's digital and innovation programme is:

- driving patient choice, accessibility and efficiency through AI-enabled 111 access, SMS cancellation, expanded language support, and digital triage tools

- supporting new models of care, with agentic AI signposting, remote triage, pathway digitisation and automation to reduce avoidable demand
- delivering measurable improvements, including reduced call handling burden, reduced wasted NEPTS journeys, reduced on-scene times, improved cardiac arrest decision support and enhanced equality of access

Collectively, these digital advances demonstrate the Trust's readiness for the future and strong alignment with the priorities for a modern, accessible and innovative NHS Wales. The Trust is actively discussing the digital opportunities it sees with partners across the system with a view to playing a part in system-wide digital solutions to a number of challenges. More detail on the internal controls in the Trust's related cyber security and information governance can be found in Part 2 Accountability Report.

Infrastructure

Estate

More recently, the Trust has focused on Clinical Contact Centre (CCC) environments alongside a number of ambulance station improvements, to further support the clinical transformation model ambitions. This ensures the Trust can work towards having the right buildings and vehicles in the right place for our staff to provide best and safest care across Wales.

The Trust's Estates Strategic Outline Programme has been fully endorsed by Welsh Government enabling it to work towards producing a series of business cases to achieve its vision, and it continues to work to consider how best to develop solutions for priority schemes.

The Trust has also supported several large-scale Estates scheme's this financial year, through its discretionary capital allocation; these include a new ambulance station in Dolgellau, significant improvements to the station in Monmouth, enhanced facilities to consolidate integrated care on the Matrix site in Swansea which in turn facilitated the ability to vacate Thanet House, and a new fleet workshop in Bangor. These were all schemes to address long standing estate condition issues. These investments will allow staff to move into fit for purpose buildings.

Fleet replacement programme

The latest Trust Fleet Strategic Outline Programme has been fully endorsed by Welsh Government enabling the Trust to produce annual Business Justification Cases (BJCs) for vehicle replacements.

Early in 2025/26 Welsh Government approved the fleet replacement BJCs for the purchase of 141 vehicles with a cost of c£22.453m; this comprised of 44 emergency ambulances, 12 single responder vehicles, 65 large ambulance care vehicles, 13 smaller ambulance care vehicles, two driver training vehicles, three fleet workshop vehicles and two occupational health vehicles. . The ability to deliver on this, on time and within budget, was in part due to the early approval of the scheme funding which allowed the Trust to secure build slots with the vehicle converters.

Environmental sustainability

WAST produced a Decarbonisation Action Plan (DAP) in response to the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan (NHSW- DSDP). The plan has a range of actions which frame the Trust's decarbonisation response and spans all directorates across the Trust.
Welsh Government, supported by Welsh Government Energy Services (WGES) has refreshed the Strategic Delivery Plan (SDP) which underpins organisation's DAPs. The Trust provided comments on two versions of the document. Version 3 was presented to the National Programme Board and the NHS Leadership Board for endorsement.

The Trust is currently in the process of reviewing the changes required to the DAP in light of the revised SDP. Within the SDP are 25 initiatives across 7 categories. The Trust are named specifically (or within the umbrella of all NHS organisations) in 36 actions.

The Trust is currently considering the methodology for the preparation of the SDP response in the form of a new plan, recognising that the Trust may need to consider some of the specific actions, and the resource implications of supporting these as programmes of work.

Within the refreshed SDP are a series of data metrics. Whilst some of this data may already be collated by the Trust, there are aspects which will require changes to Trust process, or development of mechanisms for capturing newly required data. Once these have been finalised, further consideration will need to be given to the Trust's reporting on this

information. Whilst every attempt will be made to automate data gathering and reporting, it should be noted that this will require time and resource to establish.

Welsh Government has confirmed a change to the previously set public sector carbon reduction targets of 16% reduction by 2025 and 34% reduction by 2030 for carbon emissions. Targets will now focus only on scope 1 and 2 (direct and indirect) emissions and will not include scope 3 (supply chain) emissions. The targeted reduction has been reprofiled to a 41.7% reduction by 2030 across these two categories. This also recognises achievement of the original 16% target reduction between 2018/19 and 2025, with an actual achievement of 17.7%.

Targeted Estates Funding (TEF)
The Trust was successful in obtaining funding for schemes in Abergavenny (£850k) and HART (£156k) this year. Both schemes progressed well with the HART scheme completed in year, and the Abergavenny scheme delivered by the end of the financial year.

Electric and hybrid vehicles
The Trust is in the process of introducing 10 maxus battery electric vehicle (BEV) single responder vehicles, and work is ongoing to evaluate information on battery capacity and range, charging times and performance under response conditions.

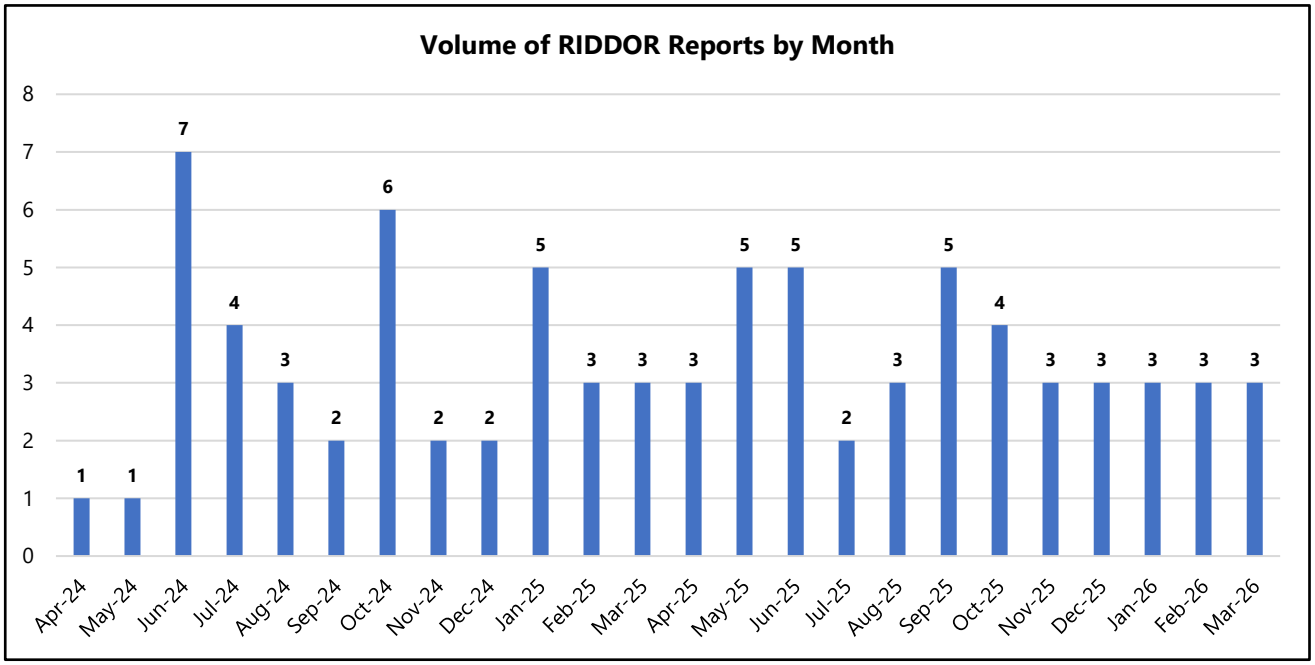
The work on implementation of previous cohorts of plug-in hybrid vehicles continues; given that there is an established mechanism for this implementation from previous vehicle procurement rounds, these have been deemed a success, and the Trust continues to support the roll out of these vehicles. However, as more vehicles are introduced to the service, work is required to assess the additional charging infrastructure required to ensure enough site capacity, allowing for effective use of these vehicles.

EV rapid charging infrastructure
The Trust has experienced some difficulties in the rapid charging market with two of the previous suppliers withdrawing from the market following successful tendering processes. Work is now focusing on installing 22kw chargers across five Trust sites in 2025/26.
Until the Trust is able to develop a programme to install rapid chargers on all major stations, the full-scale rollout of BEV ambulances will remain a significant challenge. It should also be noted that the investment required on certain sites is considerable and there are

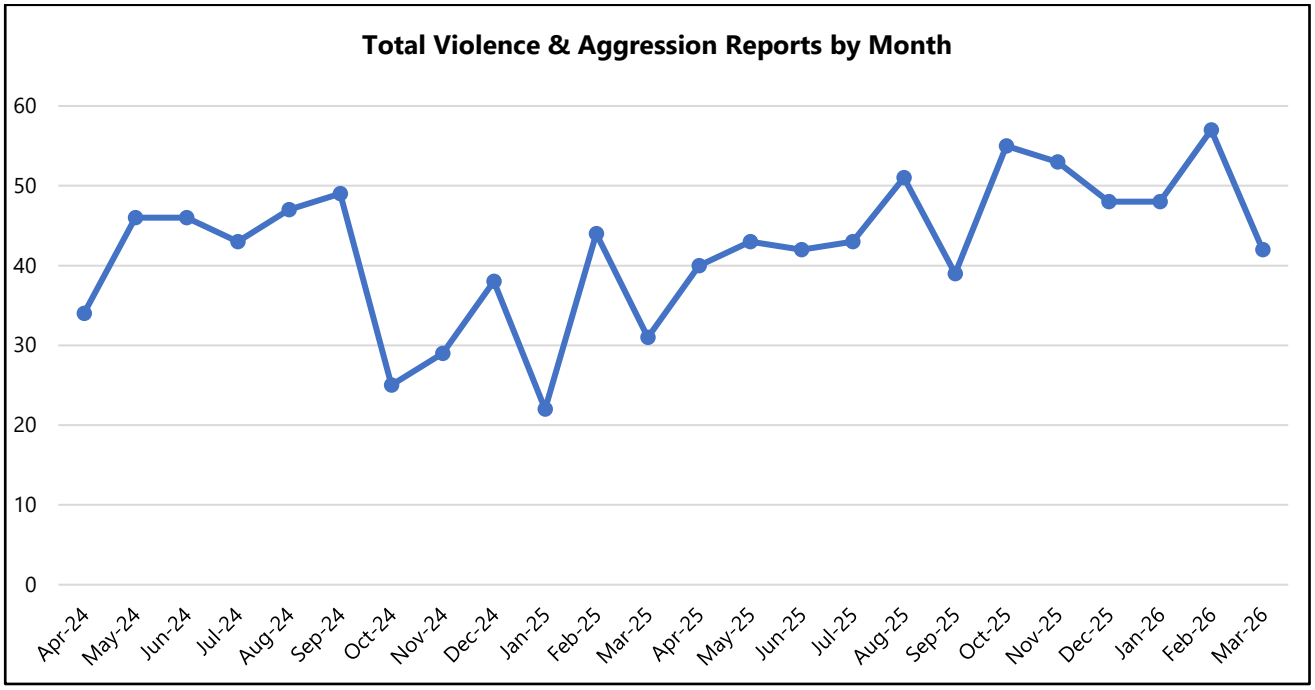
considerable challenges with distribution network operators to arrange and support the upgrades required to the existing infrastructure.

Health & Safety

The two key areas we report on are RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) and violence & aggression. The graphs for 2025/26 are below.



The volume of RIDDOR incidents has been fairly consistent over the past year, averaging 3.5 incidents per month.



The number Violence & Aggression reports received each month has seen a gradually increasing trend since early 2025 and has averaged 47 incidents a month over the past year, compared to 38 the previous year.

IMTP DELIVERY 2025/26

The 2025/26 Integrated Medium-Term Plan (IMTP) set out an ambitious and wide-ranging programme of work, underpinned by a broad set of key organisational priorities, transformational changes and areas of improvement to be delivered across the year. It was developed in line with the five ways of working sustainable development principles of the Wellbeing of Future Generations Act. The Duty of Quality Report for 2025/26 referred to above aligns with the Health and Care Quality Standards in the Quality Framework.

The Trust met the accountability conditions set by Welsh Government as part of its approval of our IMTP, the evidence for which is included in the performance report. These included delivering the objectives set by the Cabinet Secretary for Health and Social Care and the NHS Wales Planning Framework; supporting the principles of equity and social justice; undertaking robust winter planning; implementation of the new ambulance performance framework and commissioning of an evaluation thereof; delivering a community-based falls response service; improving outcomes for individuals in the purple and red categories, and responsiveness for patients in the amber / orange category; strengthening emergency planning; and delivering and sustaining a financially balanced position.

A key area of work prioritised in 2025/26 was the implementation of the new Welsh Government Ambulance Performance Framework (APF). As is illustrated in the performance overview and analysis above, this framework marked a major organisational and system-wide change in how ambulance services are measured and assessed, moving away from a predominant focus on response times towards a more outcomes-based approach that better reflects clinical effectiveness and patient experience.

In addition, the IMTP set out a range of organisation-wide improvements aimed at strengthening ways of working, modernising business processes, and enhancing the effectiveness and consistency of corporate function delivery, to better support frontline services and long-term organisational sustainability. The infographic below provides an overview of some of the organisations key achievements during 2025/26.



MINISTERIAL / SIX GOALS PRIORITIES - 2025/26 PROGRESS OVERVIEW

The Trust continued to work in close collaboration with key partners and system stakeholders to deliver key strategic changes including the Ministerial Priorities and Six Goals Priorities for Urgent and Emergency Care.

Throughout 2025-26, the Trust has remained an active partner contributing across the breadth of the Six Goals Programme., supporting the design, development and implementation of several six goals key initiatives reported through the formal programme structure, including:

- Same Day Emergency Care (SDEC)- the Trust has continued to support health board partners to embed SDEC services and increase the access and flow of 999 patients, helping to reduce demand in hospital emergency departments
- Single Points of Access (SPOA) – the Trust has supported the development and implementation of the health board SPOA models and continued work to increase the flow of appropriate 999 and 111 presenting patients.
- 'clinical consultation before conveyance' - the Trust was an active collaborator with Six Goals to design, develop and test the 'clinical consultation before conveyance' model. This model has been piloted in a number of health boards (including Hywel Dda and Swansea Bay) to route appropriate 999 calls from care homes into the (SPOA services, supporting safe and effective community-based management and reducing avoidable hospital conveyance and admission.
- National falls framework- The Trust has worked closely with system partners and the Six Goals programme to support the development of the national community-based falls framework for Wales, including the specifications for Level 1 Falls Responders and Level 2 Enhanced Falls Responders.
- In addition to this programme-wide collaboration, the Trust has delivered a range of further improvements that contribute to and support the Ministerial and Six Goals priorities. This has included the new Ambulance Performance Framework and the integrated clinical services model which are detailed in the performance analysis section above.

In 2026/27, the Trust will continue to work collaboratively with partners to deliver key Six Goals initiatives, including SPOAs, SDEC and expansion of the 'clinical consultation before conveyance' model.

This work sits alongside our contribution to the Community by Design programme, where we will continue to define and strengthen the Trust's role in supporting community-based care and improving patient outcomes closer to home.

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 (FReM). 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.

- **Senedd Cymru/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.

THE 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 Trust's management and control of resources and the extent to which the Trust complies with and evaluates its own governance requirements.

It is intended to bring together in one place matters relating to governance, risk, and control.

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.

The Directors' Report

Board Members

The details of the board and other directors who 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 set out below:

Also provided here are roles board members have with respect to committees (for example chair or lead), and statutory or board champion positions.

Voting Members of the Board 2025/26 as at 31 March 2026			
Colin Dennis 	**Trust Board Chair** Remuneration Committee Chair	**Emma Wood** 	**Chief Executive Officer (from 1 October 2025)** Accountable Officer
Jayne Beeslee	**Non-Executive Director** Chair of the Finance and Performance Committee Champion for digital	**Peter Curran**	**Non-Executive Director** Chair of the Audit, Risk and Assurance Committee, Chair of the Charity Committee Champion for armed forces and veterans

Voting Members of the Board 2025/26 as at 31 March 2026

			
Bethan Evans 	**Non-Executive Director** Chair of Quality, Patient Experience and Safety Committee Champion for Welsh Language, Infection Prevention & Control, and Putting Things Right	**Professor Hayley Hutchings** 	**Non-Executive Director** Academic Non-Executive Director, Champion for research
Ceri Jackson 	**Vice-Chair** Chair of the People and Culture Committee, Champion for mental health, older persons and speaking up safely	**Hannah Rowan** 	**Non-Executive Director** Chair of the Academic Partnership Committee Champion for equality
Lee Brooks 	**Executive Director of Operations** Champion for emergency planning	**Rachel Marsh** 	**Executive Director of Strategy, Planning and Performance** **Interim Chief Executive (19 July 2025-30 September 2025)** 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 f Audit, Risk and Assurance Committee. Charity Treasurer Fire safety champion	**Liam Williams** 	**Executive Director of Quality and Nursing** Caldicott Guardian Joint Executive Lead for Quality, Patient Experience and Safety Committee Champion for children and young people, putting things right and violence and aggression

Voting Members of the Board 2025/26 as at 31 March 2026

Andy Swinburn 	**Executive Director of Paramedicine** Joint Executive Lead for Quality, Patient Experience and Safety Committee

Non-Voting Members of the Board 2025/26 as at 31 March 2026

Estelle Hitchon 	**Director of Partnerships and Engagement** Executive Lead for Academic Partnership Committee and Charity Committee	**Carl Kneeshaw** 	**Director of People** Joint Executive Lead for People and Culture Committee, and Executive Lead for Remuneration Committee
Angela Lewis 	**Director of Culture Change** Joint Executive Lead for People and Culture Committee; Champion for Anti-racist Wales Action Plan	**Trish Mills** 	**Director of Corporate Governance/Board Secretary** Champion for Welsh Language
Hugh Parry 	**Trade Union Partner at Trust Board**	**Damon Turner** 	**Trade Union Partner at Trust Board**
Jonny Sammut 	**Director of Digital Services** Senior Information Risk Officer		

Board Members who left Board positions in-year			
Rhiannon Beaumont-Wood 	**Non-Executive Director (Until 8 February 2026)** Champion for children and young people	**Jason Killens** 	**Chief Executive Officer** Accountable Officer (Until 18 July 2025)

Further to the changes reflected in the above tables, there were interim arrangements within the executive team. Following Jason Killens having left the role of Chief Executive on the 18 July 2025, Rachel Marsh was Interim Chief Executive from the 19 July to 30 September 2025. During this time, Estelle Hitchon became Interim Executive Director of Strategy, Planning and Performance. Rachel Marsh and Estelle Hitchon returned to their substantive roles on the 1 October 2025, when Emma Wood started in her role as Chief Executive.

There were other interim arrangements in year within the executive team. Christopher Turley, Executive Director of Finance and Corporate Resources had a planned absence in year from 9 September 2025 until 7 January 2026. During this time Edward Roberts (Interim Assistant Director of Finance) was appointed as Acting Director of Finance and Corporate Resources.

The board skills matrix was updated in 2025/256 with changes to the board as they occurred. The above changes had no detrimental impact on the board or on collective decision-making.

The members of the Trust's Audit, Risk and Assurance Committee during 2025/26 were Peter Curran (Chair) Ceri Jackon, and Rhiannon Beaumont-Wood. Rhiannon Beaumont-Wood left the board on 8 February 2026.

Declarations of Interest

The register of interests for directors can be found on the Trust website Board Members Register of Interests as at 31 March 2026,. The register of interests of Trust decision-makers can be viewed on the Trust Publications page.

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.

Environmental, Social and Community Issues

The Trust is aware of the potential impact its operation has on the environment, and it is committed to, where resources allow:

- ensuring compliance with 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
- maintaining its ISO 14001 environmental management accreditation

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.

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 Officers, 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 judgements required for determining that it is fair, balanced, and understandable.

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.

Emma Wood
Chief Executive Officer
Date: 25 June 2026

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 accounts

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: 25 June 2026

Emma Wood
Chief Executive Officer
Date: 25 June 2026

Christopher Turley
Executive Director of Finance and Corporate Resources
Date: 25 June 2026

The Governance Statement

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 2026, 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.

This governance statement demonstrates how the Trust managed and controlled resources in 2025/26 and the extent to which it complied with its own governance requirements, including how the Trust has monitored and evaluated the effectiveness of these arrangements. In doing so, it brings together all disclosures relating to governance, risk, and control.
The Trust remains at escalation level one (routine arrangements). The Audit Wales Structured Assessment for 2025 found that:

- the Trust has an effective board supported by good governance arrangements
- systems for providing the board with assurance are effective and are being strengthened through further development of the board assurance framework
- a new quality plan is being implemented
- the Trust continues to report challenges to the achievement of key performance targets
- changes to how ambulances responses are measured were introduced during 2025, with a greater focus on patient outcomes; however, it is too early to know what impact the changes are having on service quality
- the Trust has a clear and approved Integrated Medium-Term Plan and has approved a set of wellbeing objectives; it is also undertaking a timely refresh of its long-term strategy
- the Trust has a significant number of change programmes underway, with finite capacity to support them - it is therefore pausing the development of some corporate plans and deferring some planned activities to protect capacity for key priorities
- the Trust managed its finances well to meet its key financial duties during 2024-25
- positively, it is reducing its reliance on non-recurrent saving; however, the Trust is facing increasingly challenging financial pressures this year which create risks to achieving its forecast breakeven position. There is a need to clarify the affordability of some of the Trust's strategic plans

The Trust's Governance Framework

Corporate governance is the way in which organisations are directed, controlled and led. It defines relationships and the distribution of rights and responsibilities among those who work with and in the organisation, determines the rules and procedures through which the organisation's objectives are set, and provides the means of attaining those objectives and monitoring performance. Importantly, it defines where accountability lies throughout the organisation.

The corporate governance framework integrates the statutory, regulatory and operating context of the Trust, sets out clear roles, responsibilities and delegations, and provides assurance by supporting the unitary Board through appropriate committee and advisory group oversight and robust internal controls.

Central to the framework are robust assurance processes, including integrated planning, performance management, risk and audit arrangements, which enable the Board to gain confidence in the delivery of strategy, quality and financial sustainability. These arrangements are underpinned by clear values, ethical standards and behaviours, reflecting the Nolan Principles and the Trust's obligations under the duty of quality and duty of candour.

The governance framework places strong emphasis on transparency, public accountability and engagement, ensuring that the Trust conducts its business openly and is accountable to patients, staff, stakeholders and Welsh Government, and that arrangements are in place to support effective Board development, enabling continuous improvement in how governance is exercised.

The Trust's integrated governance programme takes a whole system approach to ensuring these elements work together in practice. It supports the continual review and strengthening of accountability, risk and assurance arrangements, and the embedding of the Quality and Performance Management Framework from floor to board, ensuring alignment between statutory duties, strategic objectives and day to day delivery.

Legal, regulatory and accountability framework

The statutory and regulatory context sets the formal boundaries within which the board operates, including primary legislation, regulations, directions from Welsh Government, NHS Wales frameworks, and relevant codes such as the UK Corporate Governance Code and, from 1

April 2026, NHS Wales Operating and Accountability Framework. It clarifies the board's legal duties, accountability arrangements and assurance requirements.

The Trust has approved standing orders for the regulation of its work and, together with the standing financial instructions and the scheme of reservation and delegation, these provide the regulatory framework for the Trust's business conduct and define its ways of working. There were no changes to standing orders or the scheme of reservation and delegation during the reporting period, other than to board committee terms of reference which are annexed to the standing orders.

Chapter 11 of the standing financial instructions was amended in September 2025 following the introduction of the Procurement Act 2023 and associated subordinate instruments, and the Health Services (Provider Selection Regime) (Wales) Regulations 2025. Chapter 11 was updated in line with the model chapter provided by Welsh Government, with new processes implemented within the Trust and across NHS Wales Shared Services Procurement.

Non-compliance to standing orders is reported to the Audit, Risk and Assurance Committee and Trust Board, with two reports during the reporting period. One was in respect of the correct approval of two employment tribunal cases and the others related to the publication of papers in line with provision 7.4.8 of the standing orders.

The Trust's governance arrangements are designed to translate statutory and regulatory requirements into day to day operating practice. Assurance provided, particularly to board committees on compliance with Welsh Government initiatives and priorities, as well as to statutory and regulatory duties is embedded in committee terms of reference and cycles of business.

Wherever possible, legal and regulatory obligations are codified in the Trust's local policies, or in All-Wales policies which allow for appropriate monitoring and auditing. The Audit, Risk and Assurance Committee have overseen the policy programme during 2025/26 and have noted that the Trust's ambition of reaching a significant number of policies in date during 2025/26 has not been achieved due to a number of competing priorities. The Audit Wales recommendation from their 2025 Structured Assessment is to make the policy review process more efficient and practical and this is the focus for 2026/27.

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 2024/25 have been published on the Trust website here. The Audit Wales Independent Examination report on charitable funds is available in the Corporate Trustee papers from its meeting on 30 January 2026, available here.

Board roles, responsibilities and delegations

The Trust operates through a unitary board, supported by established delegations. Standing orders incorporate the scheme of reservation and delegation of powers and, alongside the standing financial instructions, set out what is reserved to the board and what is delegated, including financial and decision-making responsibilities.

The board is accountable for governance, risk management and internal control, and focuses on:

- **strategy**, setting vision, priorities, goals, resources, and understanding risks to delivery
- **embedding ethical behaviour**, shaping organisational culture and upholding integrity, probity and the Nolan Principles
- **quality**, setting expectations and accountability for high performance, Duty of Quality, and Duty of Candour
- **managing risk**, ensuring robust risk management and internal controls and visibility of principal risks
- **gaining assurance on delivery**, holding to account, and being held to account, for delivery of strategy, performance, culture and behaviours

Board and committee structure

The board comprises the Chair, Vice Chair, six Non-Executive Directors and six Executive Directors. It is supported by five additional non-voting directors and two Trade Union Partner representatives, as set out in the Directors' Report above.

During 2025/26, the board met eight times in public and eight times in private session. Decisions taken in private are reported in subsequent public board meetings, subject to the protection of confidentiality and commercial sensitivity.

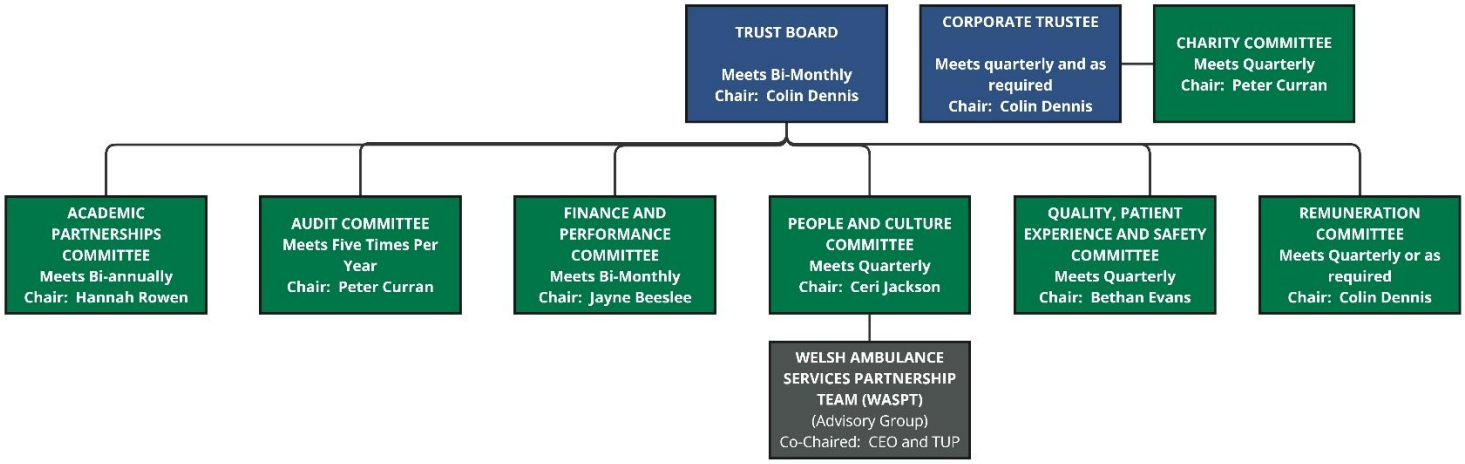
All board and committee meetings were appropriately constituted and quorate, and no scheduled meetings were stood down during the year. Six board meetings were held in person in Cardiff, with members of the public able to observe meetings virtually and submit questions in advance. At the annual general meeting, members of the public were also able to ask questions during the meeting.

Committees were largely facilitated in a hybrid format, with some meetings held virtually via Microsoft Teams. This approach supports the Trust's national remit and enables wider participation across Wales. Members of the public are able to observe these meetings.

Details of board and committee meeting dates and member attendance are included in appendix one and appendix two. Agendas and papers for public meetings are published on the Trust's website seven calendar days in advance. Committee papers, minutes and their AAA highlight report for each meeting are contained in the committee section of the Trust's website.

The board has seven standing committees, each chaired by a Non-Executive Director. Committees support the board by providing advice, gaining assurance, exercising delegated responsibilities, and enabling more detailed scrutiny than is possible at full board meetings. Each committee is supported by an executive director or director lead, who works closely with the committee Chair and the Director of Corporate Governance and Board Secretary on agenda setting, cycle of business planning, and the quality and timeliness of information.

The board and its committee structure is as follows:



The Trust's sole Advisory Group, the Welsh Ambulance Services Partnership Team (WASPT) brings together senior leaders, trade union and professional organisation representatives to discuss national priorities and agree approaches to workforce and health service issues. It provides the formal mechanism for consultation, negotiation and communication between trade unions and the Trust's senior leadership.

The group meets bi-monthly and held six meetings in 2025/26, with each meeting including an informal workshop on topical issues. Operational and corporate forums report into WASPT to enable issues to be addressed locally, allowing WASPT to operate in a more strategic space.

As set out below, each year the committees and advisory group review their effectiveness. The primary outputs of this process are revised terms of reference, improvements to operating arrangements and a committee/group annual report. The annual reports of committees provide the Audit, Risk and Assurance Committee (ARAC) with enough detail for them to assure the board that committees have discharged their responsibilities and are operating effectively.

The 2025/26 annual reports for committees - which can be accessed here - provide details of the remits of each committee. The alert, advise and assure (AAA) highlight reports also at that link set out the work of each of the committees in 2025/26 therefore this has not been duplicated in this annual report. The updated terms of reference of each committee can be viewed here.

The ARAC provides the board and the Accountable Officer with advice and assurance on whether effective arrangements are in place through the design and operation of the Trust's system of assurance to support them in their decision taking, and in discharging their

accountabilities for securing the achievement of the Trust's objectives. The committee's cycle of business is developed to deliver this role and any deviation from the cycle is escalated to the next meeting. In addition to its business as usual work, the ARAC established a sub-group in 2025/26 to undertake an exercise to streamline the committee structure (see further below).

The Remuneration Committee meets in private session. During 2025/26 the Remuneration Committee endorsed re-banding decisions for various roles; received the Chief Executive's objectives and appraisal; endorsed the appointment processes for senior manager posts; endorsed settlement agreement and voluntary early release settlements for approval by Welsh Government; endorsed the annual report remuneration table; reviewed agenda for change and executive salary payment national pay awards and undertook their quality and governance review.

Decision making and assurance processes

The Trust's governance framework includes the systems and processes required for sound decision making, oversight and assurance, including annual business planning through the Integrated Medium-Term Plan (IMTP) and local directorate plans, the Quality and Performance Management Framework, and supporting policies and procedural guidance.

The board's authority is contained in the standing orders, standing financial instructions and the scheme of reservation and delegation. The board delegates authority to the Chief Executive via that scheme, and to the board committees via their terms of reference.

The Chief Executive, as Accountable Officer, has established the Executive Leadership Team (ELT) as the Trust's principal executive decision making body. The ELT supports the Chief Executive in the day-to-day leadership and management of the Trust. Its responsibilities are underpinned by the Accountable Officer's Memorandum and, from 1 April 2026, the domains of the NHS Wales Operating and Accountability Framework.

As part of the integrated governance programme in 2026, the Trust will refresh the governance framework and the structures to which the ELT delegates work. This will strengthen the operation of assurance from floor to board, supporting clear visibility of performance and risk to the Accountable Officer and the board.

Decisions and actions at the board, committees and ELT are recorded through meeting minutes and an action log, which are reviewed and approved at each meeting. Following each committee meeting, a AAA highlight report is prepared and escalated to the board, supporting clear oversight of key risks, issues and assurance. That report is also published on the Trust website to promote timely openness and transparency.

Further details on the working of the board in 2025/26 can be found on our website here, including the biographies of members, dates of meetings, papers, minutes, and recordings of past meetings.

Risk and control framework

The Trust has established an excellent organisational and board-level risk culture, which is firmly embedded in our governance arrangements and aligned to our strategic objectives. Principal risks drive the agenda of our board and committees and are reviewed regularly at the ELT and committee meetings, ensuring robust oversight and informed decision-making. This approach enables early identification, assessment, and effective management of risks, supporting the delivery of safe, high-quality services and compliance with statutory and financial duties.

Our current strength lies in this well-developed risk culture and linkage of risks to strategic objectives. However, there is a need to mature further by developing a strategic board assurance framework that provides a clearer line of sight for the board on risks directly associated with each strategic objective, together with the strength of assurance on controls, and clear mitigations to meet identified gaps. This will enable the board to better understand where assurance is strong and where gaps remain.

The risk management section below provides further detail.

Values, behaviours and culture

The board shapes the culture of the Trust through in a myriad of ways, including how it engages with staff, patients and stakeholders, how it manages its agenda, the nature and balance of board discussions, and where it invests time and resources. Board members are expected to demonstrate the highest ethical standards of integrity and probity and to uphold the Nolan Principles.

Hearing the voices of patients and staff at board and committee meetings remains a core component of meetings and is an important triangulation for the board. Following each meeting a follow up is presented on learning and/or actions from experiences shared.

The board promotes a culture of openness and learning, ensuring that staff understand their role in the effective and high-quality provision of care, and supporting compliance with the duty of quality and duty of candour as set out in the Health and Care (Quality and Engagement) (Wales) Act 2020.

Partnership working also supports the Trust's culture and governance, including the WASPT Advisory Group as the principal partnership forum for engagement with trade unions and professional organisations.

Board effectiveness and development

The board routinely assesses the effectiveness of its governance arrangements and that of its committees and advisory group.

In late 2025 the Good Governance Institute were engaged to conduct a thorough and developmental review of the board's effectiveness to ensure it is positioned to meet the complex challenges of today and the future. This included observations from the Good Governance Institute of board, committee and ELT meetings, interviews with board members, review of documentation and a board survey.

The summary of the Good Governance Institute's report, which will be presented to the board on 30 July 2026, provided that:

> *"Our overall assessment is that the board of WAST is a good board, with the potential to be a really great one. There is clear evidence of maturity, professionalism and a shared commitment to improving patient outcomes. It is well chaired, well supported and operates with a strong sense of collective responsibility, maturity and intent. Importantly, the foundations for high performance are already in place:*
>
> - *A constructive and inclusive culture*
> - *Strong executive cohesion*
> - *Disciplined processes and generally high-quality inputs*

The opportunity at this stage is not fundamental redesign, but targeted refinement, focusing on a relatively small number of structural and behavioural shifts that would materially improve overall governance effectiveness and ultimately patient outcomes."

The full report can be found in the July 2026 board papers available after that date here, and as part of the Integrated Governance Programme in 2026 the Trust will begin to implement the findings and ensure alignment and a golden thread from floor to board.

In addition to the board's review of its quality and governance arrangements, comprehensive reviews were undertaken for each committee during 2025/26. Early in the year the ARAC established a sub-committee to ascertain if further efficiencies to the committee structure could be obtained to enable a more focused, strategic and proportionate governance framework.

The sub-committee developed a number of options which were considered by the ARAC, with the preferred option to reduce the number of committees from seven to six. The recommended approach was to disband the Academic Partnership Committee and redistribute its functions to other committees. This was agreed by the board in January 2026; however, implementation was deferred pending the outcome report from the Good Governance Institute. These recommendations will be taken forward and aligned to the Integrated Governance Programme in 2026.

As indicated above, the annual report from each committee was endorsed by the ARAC on 28 April 2026 and presented to the board at their May 2026 meeting. The ARAC noted completion of the Trust's 2025/26 programme of quality and governance reviews across board committees and endorsed all committee annual reports from 2025/26 ahead of submission to the Trust Board. ARAC was assured that the proportionate, qualitative review approach adopted this year has not identified any new issues requiring escalation beyond those already considered, providing assurance on the effectiveness of committee operation and governance arrangements. ARAC further took assurance from the alignment of this work with a wider programme of governance development, including the externally commissioned review by the Good Governance Institute and a phased approach to implementing any subsequent changes; as referenced above.

The ARAC utilised the National Audit Office effectiveness toolkit for their annual quality and governance review, drawing out for debate areas for improvement on both essential and good practice areas in the toolkit.

The thematic board development programme continued in 2025/26 with a focus on learning, reflection and understanding. Six scheduled sessions were designed to support strategic discussion, shape culture and behaviours, strengthen system and partnership working, enhance knowledge of the regulatory environment, and allow detailed briefing of complex issues ahead of formal meetings. These sessions also include feedback from non-executive directors on visits undertaken. Topics during the year included strategic planning, review of integrated quality and performance reporting, understanding and development of risk appetite statements, value based healthcare, IMTP and financial planning, and the wider political landscape for NHS Wales.

Transparency, accountability and engagement

The Welsh Government Cabinet Secretary for Health and Social Care introduced a series of public accountability meetings in 2025/26 aimed at increasing transparency and public trust in the NHS in Wales. These meetings were an opportunity for the Cabinet Secretary to scrutinise the performance of health bodies and address significant issues including performance and quality of care. The Trust's public accountability meeting took place on 5 March 2026. The evidence submission can be accessed here and the recording of the meeting can be viewed here.

Following that meeting the Cabinet Secretary recognised the professionalism, openness and seriousness with which the board and executive team are approaching the Trust's challenging transformation programme. The discussion acknowledged the sustained pressures across the wider health and care system and confirmed that, despite operating at scale in a highly constrained environment, the Trust remains organisationally stable, financially disciplined and confident in its governance arrangements. The Cabinet Secretary noted progress in the implementation of the new ambulance performance framework and clinical model, with early improvements evident in areas such as patient handover and clinical assessment, while also recognising that outcomes remain fragile and uneven, particularly for lower-acuity patients and those experiencing long waits.

The Cabinet Secretary highlighted the importance of allowing recently implemented changes time to embed and be properly evaluated, emphasising the need for demonstrable impact, learning and course correction where required, especially in relation to patient experience and waiting times. The meeting also reflected the Trust's growing role as a clinically led national system partner, using data, insight and influence to support greater consistency and integration across urgent and emergency care in Wales. In closing, the Cabinet Secretary underlined the Trust's unique system leadership opportunity as a national organisation and reaffirmed expectations that future delivery will focus on consolidating change, strengthening partnership working and continuing to improve outcomes for people across Wales.

In accordance with the Public Bodies (Admissions to Meetings) Act 1960, the Trust is required to meet in public and did so for all public board meetings in 2025/26. Members of the public can observe public meetings and submit questions in advance.

To support openness and accessibility, most committees continued to operate in hybrid format, with some meetings held virtually via Microsoft Teams. Agendas and papers for public sessions are published seven calendar days before meetings. The Trust held its 2025 AGM via Teams on 31 July 2025, and the meeting was livestreamed. The recording is available to watch here.

The Trust also receives assurance and context through engagement in relevant All Wales governance arrangements. The NHS Wales Joint Commissioning Committee is responsible for planning and commissioning emergency ambulance services, including NHS Wales 111, on an all-Wales basis. More information on this is included in the Performance Report above.

The Trust is a member of the NHS Wales Shared Services Partnership Committee, hosted by Velindre NHS Trust, which oversees shared functions across NHS Wales such as procurement, recruitment and legal services.

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 2026 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The Trust remains committed to the active and proportionate management of risk as a fundamental component of effective governance, safe service delivery and the achievement of its strategic objectives. Risk management supports informed decision making at all levels and provides clarity on the risks that would prevent us from achieving the Trust's strategic ambition. It enables appropriate challenge by the board on whether risks are being managed, treated and escalated; however, further changes are being made to improve this with the introduction of board specific dashboards and the application of tolerance and risk appetite during 2026/27.

Risk Management Framework and governance

The board is accountable for governance, risk management and internal control. The Chief Executive, as Accountable Officer, has responsibility for ensuring that a sound system of internal control is in place which supports the achievement of the Trust's objectives, while safeguarding public funds and assets. Executive directors are responsible for identification, ownership and management of risks within their portfolios, supported by clear arrangements for escalation, assurance and Board oversight.

The Director of Corporate Governance / Board Secretary leads the design, implementation and continued development of the Trust's risk management framework.

The ARAC provides focused oversight on behalf of the board, including scrutiny of the risk management programme and the development and application of risk appetite statements.

The board and its committees have received regular risk reports in 2025/26, including updates on principal and emerging risks, changes in risk exposure and consideration of mitigating actions. Committees report on debate and discussion on risk in their AAA highlight reports.

The Trust's local, directorate and corporate risks are managed using a combination of RL Datix and local documents. Our 2024/25 risk management internal audit noted that consistency of approach is vital for good risk management and appropriate escalations but also recognised that sound governance was in place to manage these risks absent a workable digital solution.

In 2025/26 work began on the development of an in-house enterprise risk management system. This is being designed to provide a robust, reliable and flexible system to manage local, directorate and corporate risks for each directorate in the Trust, but also to ensure our strategic board assurance framework (BAF) is digitised and can effectively draw intelligence from the higher rated corporate risks to inform risks against strategic objectives. In parallel, training and education on the new system is being developed.

The current BAF continues to set out the Trust's principal risks. Each are mapped to IMTP deliverables against strategic objectives. Key to the next stage of maturity in risk management is the transition from a BAF that primarily links principal risks to the delivery of strategic objectives, to a fully embedded, strategic BAF that supports longer-term board oversight and decision making. Preparatory work is underway, with agreed templates in place and the first of six strategic risks in development. Importantly, the board's increasing focus on the strategic deliverables within the IMTP, and the associated outcome measures for each strategic objective, now provides a stronger foundation from which this work can be taken forward in a measured and proportionate way.

The 2025/26 internal audit on risk management provided for reasonable assurance and notes that, despite the need for stronger alignment to strategic objectives, the BAF nevertheless provides good coverage of the Trust's principal risks and reflect regular review of controls and gaps in assurance. The review recommended closer attention to ensure completed actions translated to controls to mitigate risks.

The 2025 Audit Wales Structured Assessment noted that the Trust's plans to begin to update the long-term strategy in 2026/27 will offer a welcome opportunity to align the strategic BAF with the development of newly shaped strategic objectives.

Overall, while the Trust continues to operate in a highly challenging and risk exposed environment, it is satisfied that its capacity to identify, manage and respond to risk remains appropriate and that the system of internal control provides reasonable assurance in support of effective governance and accountability.

Risk Profile

The Trust's risk profile continues to reflect sustained system wide pressures, particularly in relation to urgent and emergency care performance, patient flow, workforce capacity and wellbeing, cyber and digital resilience, emergency preparedness and statutory compliance. These risks are subject to enhanced scrutiny, regular review and action planning, and identifies where mitigation is dependent on action by system partners.

Further detail on the Trust's principal risks are set out below, however the board's attention and that of the Quality, Patient Experience and Safety Committee has been on risks 223 (The Trust's inability to reach patients in the community causing patient harm and death) and 224 (significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe and effective service for patients). Whilst risk 223 saw a reduction from a score of 25 to 20 in 2025 due to reduced handover delays, there is still variance nationally and the board has agreed that a sustained period of reduction is required to maintain the lower score.

The board receives a report at each meeting on action the Trust is taking to mitigate avoidable patient harm. This allows the board to focus on mitigations in the control of the Trust to mitigate, and what is being managed and influenced from a system perspective.

Higher rated risks relate to cyber security (risk 260) and the Trust's ability to implement learning from the Manchester Arena Inquiry (risk 641). Both remain at a score of 20 and have not reduced during 2025/26. With respect to cyber security, the board and the Finance and Performance Committee scrutinise the actions to reduce this risk, whilst recognising that the current geopolitical environment is quite volatile. Whilst the Trust has implemented recommendations it is able to, the majority of the recommendations as a result of the Manchester Arena Inquiry require significant funding, which is why it remains at this score. However, the Trust has been able to fund some recommendations in 2026/27 and continues discussions with Commissioners on the implementation of remaining recommendations.

A snapshot of risks, their related strategic objectives and risk appetites are set out on the next page, however the full BAF can be viewed in the papers from the 2 March 2026 ARAC meeting which are available here (via accessing the 2 March papers, specifically the 'reading room' links).

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Strategic Objective	Risk Appetite	Risk ID	Risk Title	Q1	Q2	Q3	Q4
1	Open	223	Trust's inability to reach patients in the community causing patient harm and death	25	25	20	20
1	Open	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	25	25	25	25
3	Keen	260	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	20	20	20	20
1	Open	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	20	20	20	20
2	Open	160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	16	16	16	16
2	Open	558	Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures	15	15	15	15
3	Keen	671	Unauthorised or inappropriate use of AI technologies		16	16	16
6b	Open	542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan	16	16	16	16
5	Open	201a	Relationships with Stakeholders			16	16
4	Open	201b	Poor Patient Experience Affecting Reputation			16	16
5	Open	623	Failure to comply with Data Protection Legislation	15	15	10	
1	Open	620	Symptom Checkers	20	15	15	15
1	Open	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	15	15	15	15
2	Open	163	Maintaining Effective & Strong Trade Union Partnerships	12	12	12	12
4	Open	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	12	12	12	12
6a	Cautious	139	Failure to Deliver our Statutory Financial Duties in accordance with legislation	8	8	8	8
5	Open	201	Damage to Trust reputation following a loss of stakeholder confidence NB: this risk is closed and two new risks (201a and 201b above) developed	20	20		
	Risk achieved target						
	Risk closed from all registers						
	Risk not in existence						

Risk Appetite and tolerance

During 2025/26 the Trust began to embed its risk appetite framework, building on the suite of risk appetite statements agreed by the board and overseen by the ARAC. The statements articulate the level of risk the Trust is willing to accept in pursuit of each strategic objective and provide clarity on where exposure is outside tolerance and requires further action, mitigation or escalation.

Risk appetite was informed by analysis of the Trust's principal risks, board and committee risk reports, performance and quality intelligence, internal audit findings and the external operating environment. The ARAC led detailed scrutiny of draft appetite statements prior to board approval, ensuring that appetite reflects statutory responsibilities, patient safety priorities and the Trust's capacity to mitigate risk within available resources.

The Trust's risk appetite statements can be found here. Risk appetite is being implemented to inform future decision making, prioritisation, and the board's assessment of whether the Trust's risk exposure remains acceptable in the context of quality, patient safety, available resources, delivery expectations and system constraints.

Identification, escalation and management of new and emerging risks

Risks are identified and reviewed through an ongoing process embedded across the organisation. Sources include operational and performance reports, quality and safety monitoring, internal and external audit, incident reporting, serious adverse events, workforce indicators, and engagement with partners and stakeholders.

New and emerging risks are assessed using the Trust's risk assessment methodology and escalated through established governance routes, including directorate governance arrangements, the ELT and the ARAC, with onward escalation to the board and committees where appropriate. Significant new risks are recorded on the corporate risk register and incorporated into the BAF with clearly defined controls, mitigating actions and assurance sources.

During 2025/26, several new and newly evolving risks were identified and escalated through the Trust's governance arrangements, including continued system pressure across urgent and emergency care pathways, heightened cyber security threats and risks relating to sustaining workforce capacity and wellbeing. These risks were assessed, recorded on the BAF, and subject to targeted mitigating actions and enhanced board oversight.

Capability, culture and training

The Trust recognises that effective risk management is dependent on organisational capability, clarity of roles and a positive risk culture. Risk management is undertaken at all levels of the organisation and colleagues are supported through bespoke risk management sessions for teams and induction programmes, as well as basic risk management training enabling them to identify, manage and escalate risks in line with their responsibilities.

Partnership working and stakeholder engagement

Many of the Trust's most significant risks rely on effective partnership working beyond the Trust's direct control. The Trust works closely with system partners, including health boards, NHS Wales bodies and other stakeholders, to ensure shared understanding of risk, coordinated mitigation and alignment of action where risks impact on patient safety, access and service sustainability. This was particularly evident in 2025/26 when risk officers from the Joint Commissioning Committee (JCC) attended our Quality, Patient Experience and Safety Committee to observe the discussion and debate on our highest patient safety risks, which are mirrored in their risk register.

Feedback from patients, the public and stakeholders informs the Trust's risks and the development of mitigating actions, alongside intelligence from quality governance, complaints, concerns and incident reporting.

Continuous improvement

Risk management arrangements continue to evolve as part of the Trust's wider governance and assurance framework with oversight by the ARAC. Learning from internal audit, external review, board and committee scrutiny is used to strengthen risk management processes, improve clarity of reporting and enhance the board's ability to focus on the most significant threats to delivery of the Trust's strategic objectives.

Priorities for 2026/27 include the roll-out of the strategic BAF across all strategic objectives and their reporting to the board and committees aligned with evolving strategic delivery reporting. Development, testing and roll-out of the in-house enterprise risk management system will be taken forward in 2026/27 also.

Emergency preparedness and specialist operations

As a Category One NHS organisation under the Civil Contingencies Act 2004, the Trust has continued throughout 2025/26 to discharge its statutory duties for emergency preparedness, resilience, response and business continuity. Arrangements remain aligned to the NHS Wales Emergency Planning Core Guidance and Welsh Government expectations, ensuring the Trust is prepared to respond to and recover from a wide range of disruptive and emergency events. The Trust submitted its annual 2024/25 Emergency Planning Report to Welsh Government in June 2025, noting the risks set out above and a shift in its assurance position indicating that some Civil Contingency Act 2004 principles were only partially met rather than fully met, reflecting learning from the Manchester Arena Inquiry.

During 2025/26, the Emergency Preparedness, Resilience and Response (EPRR) function has focused on consolidating and embedding improvements arising from national learning and internal assurance activity. Progress has continued in relation to the Manchester Arena Inquiry recommendations, with ongoing engagement across NHS Wales, Welsh Government and Local Resilience Forum (LRF) partners.

Recommendations requiring sustained funding and longer-term delivery remain managed through the Trust's corporate risk framework to ensure appropriate oversight, assurance and executive accountability. A business case for the uplift of the South Wales-based Hazardous Areas Response Team (HART) team was submitted to Welsh Government in quarter 4, with ambition to submit a full business case for a North-based HART team in 2026/27.

Strengthening business continuity management has remained a priority throughout 2025/26. The Trust has continued to embed a consistent, organisation-wide approach to business continuity planning and reporting, supported by the implementation and use of dedicated business continuity software. This has improved the quality, visibility and assurance of business impact analyses and continuity plans across services, supporting the ambition of clearer escalation, improved assurance and greater organisational resilience.

Throughout the year, the Trust has responded to a range of significant incidents and system pressures, which have provided opportunities to test emergency response, command and control arrangements, interoperability and organisational resilience. These events have reinforced the importance of preparedness, training and strong multi-agency working, and have informed organisational learning and improvement activity within the EPRR function. The Trust has remained fully engaged with Local Resilience Forum partners across Wales, contributing to executive planning groups, training programmes and multi-agency exercises. Continued collaboration with Welsh Government and resilience partners has supported the review of the Wales Resilience Framework, which will be analysed and used to create training and exercise packages in 2026/27.

Specialist operational capability has been sustained throughout 2025/26, including HART and Specialist Operational Response Team (SORT) provision. Investment in specialist capabilities has continued to enhance the Trust's ability to respond to complex, high risk incidents, including hazardous materials, major trauma, water rescue and terrorist related events, ensuring preparedness remains aligned to national and regional risk. Currently there are 230 SORT trained staff across WAST with robust plans to reach 290 in 2026/27.

In December 2025, The Trust provided evidence to the Senedd's Public Accounts and Public Administration Committee, focussed on Welsh Government's current preparedness, response structures, and progress since the Covid-19 pandemic to address the gaps identified by the Covid-19 Special Purpose Committee (dissolved on 08 October 2025). This includes its response to the UK Covid Inquiry Module 1 report, implementation of the Module 1 recommendations, and the Welsh Government's role in Exercise Pegasus, a tier one pandemic preparedness exercise. The Committee's report was published in March 2026.

Looking ahead, the Trust recognises that the evolving national resilience landscape, increasing system pressures and the implementation of outstanding Manchester Arena Inquiry recommendations will continue to place demands on EPRR capacity and capability. The Trust will continue to work with Welsh Government, blue-light partners, Local Resilience Forums and NHS colleagues across Wales and the UK to ensure that emergency preparedness arrangements remain effective, proportionate and resilient, and that the Trust remains prepared to respond to any event or circumstance that impacts on the population it serves.

The control framework

Financial governance

The financial governance framework within the Trust provides a structured system through which financial accountability, stewardship and decision-making are exercised in support of the Trust's objectives and statutory duties. It is underpinned by standing financial instructions, the Integrated Medium-Term Plan and the accountability arrangements set by Welsh Government.

Financial governance is embedded through clearly defined roles and responsibilities, with the board retaining overall accountability for financial sustainability and control, supported by the ARAC and the Finance and Performance Committee. This framework ensures that financial planning, budgeting, monitoring and reporting are aligned with strategic priorities and that the use of public funds is lawful, effective and represents value for money.

Operationally, the framework is delivered through robust financial management processes, including budgetary control, financial performance reporting, capital and investment approvals, procurement and contract management, and the maintenance of strong internal controls. Regular reporting provides transparency on performance against plan, delivery of savings and efficiencies through the financial sustainability programme, and emerging financial risks, enabling timely scrutiny and escalation where required.

For several successive years, the financial governance framework has demonstrated robustness, supporting the achievement of a breakeven position and a good record for delivering savings, as noted in the Audit Wales 2025 Structured Assessment that indicated:

> *The Trust manages its finances well to meet its key financial duties during 2024-25. Positively, it is reducing its reliance on non-recurrent savings. Yet the Trust is facing increasingly challenging financial pressures this year which creates risks to achieving its forecast breakeven position. However, there is a need to clarify the affordability of some of the Trust's strategic plans.*

Assurance is strengthened through internal and external audit, compliance with the financial duties placed on NHS bodies in Wales, and integration with the Trust's wider risk and assurance arrangements.

Quality, safety and clinical governance

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 Quality, Patient Experience and Safety Committee (QUEST). This included the delivery of a Strategic Quality Plan for 2025-2028. The plan is supported by a detailed implementation plan, which aligns with previous Audit Wales Recommendations.

QUEST has raised concerns about delivery risks from deferring activity to later stages of the plan, given ongoing capability and capacity pressures following significant clinical model changes. QUEST will continue to monitor the plan review in 2026/27.

A significant focus of Quality Governance in 2025/26 was the establishment of robust governance arrangements to support recovery of the statutory compliance under Putting Things Right (PTR). As can be seen in the performance report above, performance was below where it should have been and it was an issue escalated to the board by QUEST on several occasions in 2025/26. As a result, a cross directorate programme board was formally established to provide structured oversight, risk management and assurance. The increased governance oversight allowed for improved visibility and transparency of process challenges and the importance of linked data and intelligence to support quality control and improvement. This programme board has been expanded to provide assurance and oversight of the Trust's approach to implementing the new Listening to People Regulations from 1 April 2026.

In September 2024 Audit Wales concluded a follow-up review of the Quality Governance audit conducted in 2022. This included a number of recommendations made in the 2022 audit remaining in progress, and additional recommendations for improvement. All identified actions to address these recommendations were completed in 2025/26.

The Quality Management Group (QMG) has continued to build connections to support an organisational approach to quality improvement and underpin the Trust's Quality Management System. Intelligence platforms within this area have continued to develop and allow us to identify areas of improvement in 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 Clinical Quality Governance Group, which is the primary clinical & quality governance forum in the

Trust reporting into the Executive Leadership Team. A key focus area for the forum this year has been the completion of quality assurance self-assessments and the development of quality statements for all organisational departments in order to support forward improvement plans through 2026/27.

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 twelve 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 Quality Performance Management Framework (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 QPMF Steering Group who provide assurance to the Executive Leadership team. All elements of the organisation across both operational and corporate services have been supported to complete a self-assessment against the framework to develop improvement plans associated with their individual quality management systems.

During 2025/26 work has progressed to establish appropriate information governance and regulatory pathways to enable the Trust to utilise service user data for targeted outreach and experiential intelligence purposes. This included the development of submissions and engagement with the Information Commissioners Office. Governance for this initiative was overseen through the Information Governance Steering Group and QMG.

The Trust develops an annual clinical audit plan in line with national and local priorities. The audit plan is reported to QUEST quarterly, with any deviations in the plan agreed. QUEST in turn assures the Audit, Risk and Assurance Committee that the clinical audit plan is in place and being monitored. The Trust's annual Quality Plan for 2025/26 can be accessed here.

Information governance arrangements (including information 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 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 Executive Leadership Team monthly and provides assurance on the Trust's compliance with relevant information governance standards. Oversight at board level is through the Finance and Performance

Committee, and the board's digital non-executive director works closely with the Digital Director on emerging issues.

The Trust continues to provide annual submissions to the Welsh Information Governance Toolkit. The results of the March 2026 submission are that the Trust is meeting all minimum standards at the point of submission, with eight out of the twelve categories exceeding expectations.

There is an existing risk on the corporate risk register related to failure to comply with data protection and a new risk on the unauthorised or inappropriate use of AI technologies. The risks and mitigation actions continue to be monitored.

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. This has been a focus of the Information Governance Steering Group in 2025/26, and raising the profile of these is a key priority in 2025/26.

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. 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 of 1 April 2025 to 31 March 2026, three incidents were notified to the ICO. Following notification, one report was rescinded, and no further action has been received from the ICO in relation to the two remaining incidents.

Corporate Governance Code compliance

An assessment against the corporate governance code for central government departments (2017), has been completed using the "Comply" or "Explain" approach. Whilst there is no requirement to comply with all elements of the code, an assessment was undertaken in April 2026 against the main principles as they relate to an NHS public sector organisation in Wales. The results were reviewed by the Audit, Risk and Assurance Committee on 28 April 2026 and the papers for that meeting can be accessed here.

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 2025/26 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.

Planning arrangements

In accordance with expectations from Welsh Government, the Trust submitted its 2025-28 Integrated Medium-Term Plan (IMTP) by 31 March 2025 following its approval by the Board on 27 March 2025. The IMTP 2025-28was approved by Welsh Government on 30 June 2025, subject to Accountability Conditions; which were provided to the Trust on the 28 July 2025.

The IMTP was shaped with internal and external feedback and in line with the NHS Wales Planning Framework 2025-28. This included patient stories, staff surveys and engagement with the Joint Commissioning Committee, the board and other key stakeholders.

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.

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 staff to help them recognise, promote, and celebrate equality, diversity, and inclusion. This Plan includes the 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 the Trust's 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 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. In 2026/27 the Trust will continue to work closely with NHS Wales

partners on adaptation planning and will further develop our Climate Change Adaptation Plan which will ensure a structured, organisation-wide approach to building a comprehensive risk matrix and associated adaptation measures. The approach is deliberately collaborative and is being created with input from colleagues across all directorates, ensuring full organisational engagement, shared ownership, and a robust evidence base. This will enable us to identify, assess and prioritise risks consistently, and to develop proportionate and achievable adaptations that are embedded into business-as-usual planning.

- The Trust had no reported serious untoward incidents during 2025/26 in relation to data security. As set out above, three incidents were notified to the ICO. Following notification, one report was rescinded, and no further action has been received from the ICO in relation to the two remaining incidents.

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.

The recommendations and actions from the Data Quality Internal Audit of October 2024 have been completed and implemented, with the Information Governance Steering Group (which has delegated authority from the Executive Leadership Team) now monitoring data quality related metrics and training progress monthly. Notably, this has included the development and release of a bespoke data quality training & awareness module across the Trust, and the re-establishment of an Information Asset Management Group for data stewards and information system owners.

Following the implementation of the Ambulance Performance Framework (Phases 1 and 2) in 2025, the data supplied by WAST to the Welsh Government as part of the Official Statistics Release has been completely redesigned to align with the new metrics, tested, and quality assured by the Insight & Data Services function of the Digital Directorate. The data behind these submissions are also part of a continuous data quality monitoring process, checking across all dimensions of data quality as 999 and 111 related call and incident data are brought into the Trust's secure, on-premise data warehouse. 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 and collaborative approach. As such, the Trust retains its status on The Official Statistics (Wales) Order 2017, which is part of the Statistics and Registration Services Act 2007.

More broadly across the Trust, data quality for other information systems and sources is maturing. At the Finance & Performance Committee meeting of November 2025 it was noted that a data reporting error had been identified related to compliance metrics for Putting Things Right (PTR) in the MIQPR. The cause of this error was largely reliance on manual extraction and calculation of data from a third-party system. In recent months, significant data engineering effort has been directed to this area of information, to improve the technical data flow, and allow the metrics to be calculated in a more automated and reliable way, improving confidence in the reporting accuracy for future.

Another notable improvement for data quality maturity within WAST includes the approach by which the new Ambulance Performance Framework metrics were designed collaboratively by subject matter experts from across the Trust (from data, clinical, commissioning, and operational teams). This best practice approach is being adopted by other workstreams of the Clinical Model Transformation programme going forward.

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 2025 to 31 March 2026 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.

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.

At the most recent tripartite meeting the escalation status of the Trust remained unchanged at 'routine arrangements', a status that has been maintained for a number of years.

Health Inspectorate Wales

There were no HIW reports received in 2025/26, however a local review was commenced in 2026 on several themes including:

- patient flow and handover process, releasing crews quicker/alternative pathways, standardising handover guidance/SOPs
- escalation process
- communication with patients about delays
- leadership presence and governance, reporting, learning and feedback culture, workforce planning and staffing levels, staff wellbeing and support, staff training and development
- data quality and accurate reporting

The outcome report has not been received in this financial year.

Welsh Risk Pool

During 2024 the Welsh Risk Pool (WRP) undertook its annual 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 concerns management and compliance with Putting Things Right Guidance for the WRP Committee, Welsh Government and NHS Wales Performance and Improvement 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.

Recommendations were approved by Welsh Risk Pool Committee, with ongoing monitoring, challenge and closure oversight provided by the Trust's Audit, Risk and Assurance Committee.

During the year, there was some slippage against original completion timescales, reflecting sustained demand, operational pressures and capacity constraints across the organisation. Notwithstanding this, most actions have now been completed and agreed for closure, supported by appropriate evidence demonstrating delivery against each recommendation. A small number of actions remain open due to significant dependencies on digital infrastructure and nationally-procured solutions that fall outside the Trust's direct control. To strengthen assurance and accelerate progress, the Trust has established senior-level oversight of digital prioritisation. This provides clearer governance, stronger alignment with IMTP priorities and strategic risks, and enhanced engagement with national partners where system-wide solutions are required.

Internal audit

Internal Audit provides the Accountable Officer and the Trust Board with an independent flow of assurance on the adequacy and effectiveness of the system of internal control. The Accountable Officer commissions a programme of internal audit work, which is delivered in accordance with Global Internal Audit Standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Executive Leadership Team and the Audit, Risk and Assurance Committee and is focussed on areas of significant risk 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. In forming the opinion, the Head of Internal Audit has considered the impact of any audits that have not been fully completed. As in previous years, audit work undertaken at NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the NHS Wales Joint Commissioning Committee (JCC), has contributed to, and supports, the overall internal audit opinion for NHS Wales health bodies.

The Head of Internal Audit has concluded:

- + 	The Trust Board can take **reasonable assurance** that arrangement to secure governance, risk management and internal control, withi 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 2024/25 Annual Governance Statement. The 2025/26 reasonable assurance conclusion is derived from 20 Internal Audit reviews.

Internal Audit Assurance Conclusion	Number of Reports
Unsatisfactory Assurance	0
Limited Assurance	0
Reasonable Assurance	17
Substantial Assurance	2
Advisory	1
In progress	0
Total	**20**

For the eighth consecutive year there have been no 'Unsatisfactory Assurance' internal audit reports of Trust business. Of the 20 reports completed in year, none were rated as limited, with the majority of reports being rated as having 'reasonable' assurance.

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 2025 Trust conducted the following reviews:

- Structured Assessment 2025 – core assessment
- Structured Assessment 2024 – deep dive review of investment in digital systems
- Urgent and Emergency Care – arrangements for managing demand Welsh Ambulance Services University NHS Trust

Structured Assessment 2025

The key focus of this review was 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 that the Trust has an effective board, supported by strong and maturing governance and assurance arrangements, a clear planning framework, and sound financial management, while operating in a challenging performance and financial environment with constrained organisational capacity. Its key findings included:

> *We found that the Trust has an effective Board supported by good governance arrangements. Systems for providing the Board with assurance are effective and are being strengthened through further development of the board assurance framework. A new quality plan is being implemented, but its deliverability is likely to be challenging without dedicated funding. The Trust continues to report challenges to the achievement of key performance targets. Changes to how ambulances responses are measured were introduced during 2025, with a greater focus on patient outcomes. However, it is too early to know what impact the changes are having on service quality.*
>
> *The Trust has a clear and approved Integrated Medium-Term Plan (IMTP) and has recently approved a set of wellbeing objectives. It is also undertaking a timely refresh of its long-term strategy. The Trust has a significant number of change programmes underway, with finite capacity to support them. It is therefore pausing the development of some corporate plans and deferring some planned activities to protect capacity for key priorities.*

The Trust manages its finances well to meet its key financial duties during 2024-25. Positively, it is reducing its reliance on non-recurrent savings. Yet, the Trust is facing increasingly challenging financial pressures this year which creates risks to achieving its forecast breakeven position. However, there is a need to clarify the affordability of some of the Trust's strategic plans.

Recommendations related to strengthening policy management, enhancing reporting of the current board assurance framework; clarifying delivery of the quality plan, and reporting issues of timely submission of board and committee papers. All recommendations were accepted and are being monitored by the ARAC. The Audit Wales Structured Assessment report for 2025 is available within the 2 December 2025 ARAC papers, here.

Urgent and Emergency Care – arrangements for managing demand
Whilst fieldwork was undertaken in 2024/25 this report was finalised in April 2025. The report can be accessed here.

It was the second phase of a programme of work focused on several elements of the urgent and emergency care system in Wales. The first phase examined discharge planning and the impact of patient flow on urgent and emergency care covered the health board and local authorities for each of the seven health and social care regions.

The review looked at how the Trust was managing demand for urgent and emergency care services. Specifically, how the Trust was 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 overall conclusion was 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. Recommendations were made to address the accuracy of the 111 Wales website and directories of service.

Audit Wales will provide the final part of their work on urgency and emergency care in Q1 2026/27, taking account of the findings in the first phase and this review.

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 (NWSSP).

Review of effectiveness of the system of internal control

As Accountable Officer for the Trust I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other report.

The Trust has established and maintained a sound system of internal control that supports the achievement of its strategic objectives, safeguards public funds and assets, and ensures compliance with statutory and regulatory requirements. The focus for 2025/26 as can be seen in the performance report has been on the transformation of the clinical model and implementation of the new ambulance performance framework. The Clinical Model Transformation Programme Board was central to this. An Internal Audit review on the management of the programme board in January 2026 looked at whether appropriate assurances and reporting mechanisms were in place and returned reasonable assurance.

The ARAC approves the annual internal audit plan and reviews all audits, reporting to the board and myself as Accountable Officer on its discussions and views on risks and progress against actions to mitigate risks.

The system of internal control is designed to manage, rather than eliminate, the risk of failure to achieve objectives and to provide reasonable, not absolute, assurance of effectiveness. It is underpinned by clear governance and accountability arrangements, effective risk management processes, robust financial and operational controls, and a framework of All-Wales and local policies, procedures, national and clinical guidelines, and delegated authority. The new strategic BAF, providing a line of sight to the board of the risks to achievement of each

strategic objective, alongside assurance reporting to board committees on achievement of deliverables for each strategic objective will further strengthen our risk management framework in 2026/27.

The positive Audit Wales Structured Assessment 2025 and Head of Internal Audit Opinion for 2025 support the robustness of the internal controls at WAST. Assurance on the system of internal control is provided through management reporting directly into the Executive Leadership Team (ELT) thereby highlighting areas requiring improvement. Agreed improvement plans on areas such as concerns management, improvements to processes for policy and risk management, and a refresh of the internal governance structures reporting to the ELT will further strengthen the internal control environment in 2026/27.

Corporate Governance Report conclusion

As Accountable Officer, I conclude that during 2025/26 no significant internal control or governance issues have been identified.

The Trust has operated within a clear governance framework, underpinned by established roles, effective committee structures and assurance processes. Board and committee arrangements have supported appropriate scrutiny, challenge and decision making, with a strong emphasis on transparency, public accountability and ethical standards.

The Trust's risk management framework reflects a mature and embedded risk culture, with principal risks actively owned, debated and escalated through established governance routes. The current board assurance framework (BAF) provides meaningful oversight of principal risks, while recognising that further maturity is required to strengthen the strategic line of sight between objectives, risk, controls and assurance. The planned transition towards a BAF aligned to strategic objectives and risk appetite is therefore appropriately framed as a measured development rather than an accelerated redesign.

The system of internal control has continued to provide reasonable assurance that risks to the achievement of objectives are being managed effectively. This is supported by management reporting, internal and external audit activity, and the work of the Audit, Risk and Assurance Committee in providing independent challenge and assurance to the board and Accountable Officer. The reasonable assurance Head of Internal Audit opinion and the positive Audit Wales Structured Assessment findings reinforce this position. Financial governance arrangements have also remained strong, with the Trust maintaining financial balance and meeting its key financial duties in a highly constrained system environment.

The governance statement highlights areas where further improvement is required, most notably in relation to Putting Things Right. During 2025/26, performance against statutory concerns management requirements was scrutinised closely and escalated by the Quality, Patient Experience and Safety Committee on several occasions. The Board responded by strengthening executive oversight and establishing more structured governance arrangements to improve grip, transparency and assurance. These actions are being monitored and will continue to be a focus for improvement.

The year has been marked by significant organisational change delivered at pace, particularly through the clinical model transformation and the new ambulance performance framework. It is therefore appropriate that the coming period focuses on consolidation, evaluation and targeted improvement. The integrated governance programme, alongside the Good Governance Institute review, will provide an opportunity to strengthen floor to board assurance and support the board's development from a good board to a high performing one, progressed at a pace proportionate to the Trust's routine escalation status and overall organisational stability.

Emma Wood
Chief Executive Officer
Date: 25 June 2026

Accountability Report 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 2025/26 (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: 8 of 9 Trust Board (Private): 8 of 9 Audit, Risk and Assurance Committee: 5 of 5 Charity Committee: 4 of 4 Finance and Performance Committee: 6 of 6 Remuneration Committee: 7 of 7
Colin Dennis	Trust Board Chair	Trust Board (Public): 8 of 9 Trust Board (Private): 7 of 9 Remuneration Committee: 7 of 7 Quality, Patient Experience & Safety Committee: 1 of 1 [extraordinary]
Emma Wood (Appointed 1 October 2025)	Chief Executive	Trust Board (Public: 4 of 4 (of available meetings) Trust Board (Private: 4 of 4 (of available meetings) Audit Risk and Assurance Committee: 1 of 2 (of available meetings - not a required attendee) Finance & Performance Committee: 1 of 3 (of available meetings - not a required attendee) Quality, Patient Experience & Safety Committee: 1 of 3 (of available meeting not a required attendee) Remuneration Committee: 2 of 2 (of available meetings)
Rhiannon Beaumont-Wood (appointed 11 Novem 2024 – left 8 February 2026)	Non-Executive Director	Trust Board (Public); 5 of 8 (of available meetings) Trust Board (Private): 4 of 7 (of available meetings) Audit, Risk and Assurance Committee: 4 of 4 (of available meetings) Quality, Patient Experience & Safety Committee: 6 of 6 Remuneration Committee: 5 of 6 (of available meetings)
Jayne Beeslee	Non-Executive Director	Trust Board (Public); 7 of 9 Trust Board (Private): 7 of 9 Academic Partnership Committee: 2 of 2 Finance and Performance Committee: 6 of 6 Remuneration Committee: 6 of 7
Bethan Evans	Non-Executive Director	Trust Board (Public): 5 of 9 Trust Board (Closed): 6 of 9 Audit, Risk and Assurance Committee: 1 of 1 [as Chair of QuEST – not a required attendee] Finance and Performance Committee: 5 of 6 People and Culture Committee: 3 of 4 Quality, Patient Experience & Safety Committee: 6 of 6 Remuneration Committee: 4 of 7

Name	Position	Board and Committee Record of Attendance (Actual attendance of total held meetings or total meetings available to attend, dependent on appointment dates)
Hayley Hutchings	Non-Executive Director	Trust Board (Public); 8 of 9 Trust Board (Private): 9 of 9 Academic Partnership Committee: 2 of 2 People and Culture Committee: 4 of 4 Remuneration Committee: 5 of 7 Audit Risk and Assurance Committee: 1 of 1 [for Quorum – not a required attendee]
Ceri Jackson	Non-Executive Director	Trust Board (Public): 9 of 9 Trust Board (Closed): 9 of 9 Audit, Risk and Assurance Committee: 5 of 5 Charity Committee: 4 of 4 People and Culture Committee: 4 of 4 Quality, Patient Experience & Safety Committee: 5 of 6 Remuneration Committee: 6 of 7
Hannah Rowan	Non-Executive Director	Trust Board (Public): 6 of 9 Trust Board (Closed): 5 of 9 Academic Partnership Committee: 2 of 2 Charity Committee: 2 of 4 People and Culture Committee: 3 of 4 Remuneration Committee: 1 of 7
Jason Killens (left 18 July 2025)	Chief Executive	Trust Board (Public): 4 of 4 (of available meetings) Trust Board (Closed): 2 of 3 (of available meetings) Remuneration Committee: 3 of 3 (of available meetings) Audit Risk and Assurance Committee: 1 of 2 (of available meetings – not a required attendee)
Lee Brooks	Executive Director of Operations	Trust Board (Public): 7 of 9 Trust Board (Closed): 6 of 9 Charity Committee: 3 of 4 Finance and Performance Committee: 4 of 6 People and Culture Committee: 3 of 4 Quality, Patient Experience & Safety Committee: 3 of 6
Carl Kneeshaw	Director of People	Trust Board (Public): 7 of 9 Trust Board (Closed: 7 of 9 Audit, Risk and Assurance Committee: 4 of 5 Academic Partnership Committee: 1 of 2 Finance and Performance Committee: 6 of 6 People and Culture Committee: 4 of 4 Remuneration Committee: 7 of 7
Angela Lewis	Director of Culture Chang	Trust Board (Public): 8 of 9 Trust Board (Closed): 7 of 9 People and Culture Committee: 4 of 4
Estelle Hitchon	Director of Partnerships a Engagement	Trust Board (Public): 8 of 9 Trust Board (Closed): 7 of 9 Academic Partnership Committee: 2 of 2 Audit Risk and Assurance Committee: 1 of 1 [not a required attendee] Charity Committee: 4 of 4 People and Culture Committee: 4 of 4
Rachel Marsh (Interim CEO between 19 July – 1 October 2025)	Executive Director of Strategy, Planning and Performance	Trust Board (Public): 9 of 9 Trust Board (Closed): 9 of 9 Finance and Performance Committee: 1 of 6 [Deputy attended] Quality, Patient Experience & Safety Committee: 4 of 6 Remuneration Committee: 2 of 2 (of available meetings as Interim CEO)
Trish Mills	Director of Corporate Governance / Board Secretary	Trust Board (Public): 9 of 9 Trust Board (Closed): 9 of 9 Academic Partnership Committee: 0 of 2 [Deputy attended] Audit, Risk and Assurance Committee: 5 of 5 Charity Committee: 4 of 4 Finance and Performance Committee: 6 of 6

Name	Position	Board and Committee Record of Attendance (Actual attendance of total held meetings or total meetings available to attend, dependent on appointment dates)
		People and Culture Committee: 4 of 4 Quality, Patient Experience & Safety Committee: 4 of 6 Remuneration Committee: 7 of 7
Jonny Sammut	Director of Digital Service	Trust Board (Public): 8 of 9 Trust Board (Private): 6 of 9 Academic Partnership Committee: 0 of 2 [Deputy attended] Finance and Performance Committee: 5 of 6 Quality, Patient Experience & Safety Committee: 2 of 6 [Deputy attended]
Andy Swinburn	Executive Director of Paramedicine	Trust Board (Public): 8 of 9 Trust Board (Closed): 8 of 9 Academic Partnership Committee: 2 of 2 Charity Committee: 4 of 4 People and Culture Committee: 3 of 4 Quality, Patient Experience & Safety Committee: 5 of 6
Christopher Turley	Executive Director Financ and Corporate Resources	Trust Board (Public): 6 of 9 Trust Board (Closed): 7 of 9 Audit, Risk and Assurance Committee: 4 of 5 Charity Committee: 3 of 4 Finance and Performance Committee: 3 of 6 [Deputy attended] People and Culture Committee: 1 of 4
Liam Williams	Executive Director of Qua and Nursing	Trust Board (Public): 7 of 9 Trust Board (Closed): 6 of 9 Audit, Risk and Assurance Committee: 3 of 5 Finance and Performance Committee: 4 of 6 People and Culture Committee: 0 of 4 [Deputy attended] Quality, Patient Experience & Safety Committee: 6 of 6

Accountability Report appendix 2: Board and Committee meeting dates

The following table sets out the dates of the board and committee meetings held in 2025/26.

Meeting Title [meetings held]	Meeting Dates 2025/26
Trust Board (Public) [9]	7 May 2025 (extraordinary); 29 May 2025; 26 June 2025; 31 July 2025; 25 September 2025; 23 October 2025 (extraordinary); 27 November 2025; 29 January 2026; 26 March 2026
Trust Board (Closed) [9]	29 May 2025; 26 June 2025; 3 July 2025 (extraordinary); July 2025; 25 September 2025; 27 November 2025; 29 January 2026; 26 February 2026 (extraordinary); 26 March 2026
Corporate Trustee [4]	29 May 2025; 31 July 2025; 27 November 2025; 29 January 2026
Academic Partnership Committee [2]	7 October 2025; 6 March 2026
Audit, Risk and Assurance Committee [5]	1 May 2025; 24 June 2025; 2 September 2025; 2 December 2025; 2 March 2026
Charity Committee [4]	2 April 2025; 3 July 2025; 2 October 2025; 13 January 2026
Finance and Performance Committee [6]	20 May 2025; 21 July 2025; 16 September 2025; 18 November 2025; 20 January 2026; 17 March 2026
People and Culture Committee [4]	15 May 2025; 12 August 2025; 13 November 2025; 10 February 2026
Quality, Patient Experience and Safety Committee [6]	9 May 2025; 13 June 2025 (extraordinary); 5 August 202 10 October 2025 (extraordinary); 4 November 2025; 3 February 2026
Remuneration Committee [7]	15 May 2025; 3 June 2025; 11 July 2025; 25 July 2025; 3 September 2025; 4 December 2025; 13 March 2026

Accountability Report Appendix 3: Glossary

ABBREVIATION	TERM
AAA	Alert, Assure, Advise Report
ACA1/2	Ambulance Care Assistant
ADLT	Assistant Directors' Leadership Team
AfC	Agenda for Change
AGM	Annual General Meeting
AMR	Antimicrobial Resistance
APC	Academic Partnership Committee
APF	Ambulance Performance Framework
APPs	Advanced Paramedic Practitioners
AQIs	Ambulance Quality Indicators
ARAC	Audit, Risk and Assurance Committee
ARWAP	Anti Racist Wales Action Plan
BAF	Board Assurance Framework
BI	Business Intelligence
CVUHB	Cardiff and Vale University Health Board
CAS	Clinical Assessment System
CASC	Chief Ambulance Services Commissioner
CC	Charity Committee
CCC	Clinical Contact Centres
CFRs	Community First Responders
CHARU	Cymru High Acuity Response Unit
CIAT	Clinical Intelligence and Assurance Team
COPI	Control of Patient Information Regulations
COSHH	Control of Substances Hazardous to Health
CPD	Continual Professional Development
CPR	Child Practice Reviews
CardioPR	Cardiopulmonary Resuscitation
CMT	Clinical Model Transformation
CRM	Clinical response Model
CRR	Corporate Risk Register
CQGG	Clinical Quality Governance Group
CSD	Clinical Support Desk

ABBREVIATION	TERM
CTP	Clinical Transformation Programme
DAP	Decarbonisation Action Plan
DEEE	Diesel Engine Exhaust Emissions
DPIA	Data Protection Impact Assessment
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
GRS	Global Rostering System
HART	Hazardous Area Response Team
HEIW	Health Education and Improvement Wales
HIW	Health Inspectorate Wales
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
IRP	Incident Response Plan
JCC	Joint Commissioning Committee
JESIP	Joint Emergency Services Interoperability Principles
JIF	Joint Investigations Framework
JOL	Joint Organisational Learning
LCFS	Local Counter Fraud Service
LRF	Local Resilience Forum/Fora
MACA	Military Aid to Civil Authorities

ABBREVIATION	TERM
MAI	Manchester Arena Inquiry
MDS	Minimum Data Set
MHRV	Mental health response vehicle
MIQPR	Monthly Integrated Quality and Performance Report
NEPTS	Non-Emergency Patient Transport Service
NHSDW	NHS Direct Wales
NQP	Newly Qualified Paramedic
NRIs	National Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
PADRs	Performance and Development Reviews
PCC	People and Culture Committee
PENNA	Patient Experience National Network Awards
PECI	Patient Experience and Community Involvement
PPE	Personal Protective Equipment
PSOW	Public Service Ombudsman for Wales
QIA	Quality Impact Assessment
QMG	Quality Management Group
QPMF	Quality and Performance Management Framework
QuEST	Quality, Patient Experience and Safety Committee
Q1, Q2, Q3, Q4	Quarter (of the financial year)
RemCom	Remuneration Committee
RCRP	Right Care Right Person
RCS	Rapid Clinical Screening
REAP	Resource Escalation Action Plan
RICS	Remote Integrated Care Service
RPE	Respiratory Protective Equipment
RPB	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

ABBREVIATION	TERM
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
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

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.

Remuneration

The definition of senior managers as prescribed by the 2025/26 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 Trust Board Chair and Chief Executive; and five further (non-voting) Directors.

Membership of the Remuneration Committee

The Remuneration Committee is chaired by the Trust Board Chair and comprises all Non-Executive Directors as members. Also in attendance is the Chief Executive, the Director of People and the Board Secretary. Details of those individuals are in the directors' report above.

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 personal and developmental review (PADR) 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 2025/26, a 3.25% consolidated pay uplift was applied to all pay scales for individuals holding executive and senior posts, effective from 1 April 2025. This pay uplift was agreed in February 2026 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.

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 - four weeks
- band seven - eight weeks
- bands eight and nine - 12 weeks

The notice provisions for pay bands one to seven outlined above are the normal 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 weeks' notice for each completed year of service up to and including a maximum of 12 weeks' notice after 12 years of continuous employment.

The above 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.

Non-Executive Directors are appointed by the Welsh Government for fixed term periods.

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 2025/26.

Remuneration relationship

Details of the Trust's remuneration relationship is set out in Note 10.6 of the 2025/26 annual financial accounts.

Senior managers in post in 2025/26

Name	Position Title	Assignment Category	Start Date in Position	Fixed Term End Date
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	4 December 2026
Hayley Hutchings	Non-Executive Director	Fixed Term	11 November 2024	10 November 2028
Ceri Jackson	Vice Chair	Fixed Term	1 July 2024[1]	30 June 2028
Hannah Rowan	Non-Executive Director	Fixed Term	01 April 2022	31 March 2030
Lee Brooks	Executive Director of Operations	Permanent	8 July 2019	Not Applicable
Estelle Hitchon	Director of Partnerships and Engagement	Permanent	01 December 2015	Not Applicable
Carl Kneeshaw	Director of People	Permanent	01 November 2024	Not Applicable
Angela Lewis	Director of Culture Change	Fixed Term	12 September 2022	31 October 2026
Rachel Marsh	Director of Strategy Planning & Performance	Permanent	01 November 2019	Not Applicable

[1] Ceri Jackson was appointed as a Non-Executive Director on 01 April 2021 and then as Vice Chair on 01 July 2024

Name	Position Title	Assignment Category	Start Date in Position	Fixed Term End Date
Patricia Mills	Director of Corporate Governance/Board Secretary	Permanent	02 August 2021	Not Applicable
Jonathan Sammut	Director of Digital Services	Permanent	27 September 2023	Not Applicable
Andrew Swinburn	Executive Director of Paramedicine	Permanent	01 December 2021	Not Applicable
Christopher Turley	Executive Director of Finance & Corporate Resources	Permanent	01 February 2020	Not Applicable
Liam Williams	Executive Director of Nursing	Permanent	01 August 2022	Not Applicable
Emma Wood	Chief Executive	Permanent	01 October 2025	Not Applicable

Further details of the contract arrangements of the Trust's senior managers in 2025/26 can be found in the remuneration table (and notes) set out below.

Senior managers filling posts on an interim basis during 2025/26

Additional detail on these interim positions is set out in the directors' report above.

Name	Position Title	Assignment Category	Start Date in Position	End Date
Rachel Marsh	Chief Executive	Interim	19 July 2025	30 September 2025
Estelle Hitchon	Director of Strategy Planning & Performance	Cover	19 July 2025	30 September 2025
Edward Roberts	Acting Director of Finance and Corporate Resources	Acting up	9 September 2025	7 January 2026

Senior managers who left the Trust during 2025/26

Name	Position Title	Assignment Category	Start Date in Position	Leaving Date
Rhiannon Beaumont-Wood	Non-Executive Director	Fixed Term	11 November 2024	08 February 2026
Jason Killens	Chief Executive	Permanent	24 September 2018	18 July 2025

Hutton Report 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. This is set out below:

Total Pay and benefits				**£'000**			**£'000**
Chief Executive Total pay and benefits range				**190-195**			**185-190**
Highest paid Director Total pay and benefits range				**190-195**			**185-190**
		2025-26	**2025-26**	**2025-26**	2024-25	2024-25	2024-25
		£	**£**		£	£	
		Chief			Chief		
Total pay and benefits		**Executive**	**Employee**	**Ratio**	Executive	Employee	Ratio
	25th percentile pay ratio	192,500	31,371	**6.14:1**	187,500	30,420	6.16:1
	Median pay	192,500	41,644	**4.62:1**	187,500	38,999	4.81:1
	75th percentile pay ratio	192,500	53,828	**3.58:1**	187,500	53,416	3.51:1
Salary component of total pay and benefits							
	25th percentile pay ratio	192,500	26,999		187,500	26,060	
	Median pay	192,500	33,992		187,500	30,420	
	75th percentile pay ratio	192,500	47,280		187,500	45,637	
		Highest			Highest		
		Paid			Paid		
Total pay and benefits		**Director**	**Employee**	**Ratio**	Director	Employee	Ratio
	25th percentile pay ratio	192,500	31,371	**6.14:1**	187,500	30,420	6.16:1
	Median pay	192,500	41,644	**4.62:1**	187,500	38,999	4.81:1
	75th percentile pay ratio	192,500	53,828	**3.58:1**	187,500	53,416	3.51:1
Salary component of total pay and benefits							
	25th percentile pay ratio	192,500	26,999		187,500	26,060	
	Median pay	192,500	33,992		187,500	30,420	
	75th percentile pay ratio	192,500	47,280		187,500	45,637	

In 2025/26, 0 (2024/25, 0) employees received remuneration in excess of the highest-paid director. Remuneration for all staff ranged from £23,875 to £192,500 (2024/25, £23,970 to £187,500). The all-staff range includes directors with the exception of the highest paid CEO

Director as appropriate and excludes the non-executive directors 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 2025/26 are the 3.6% pay increase for employees covered by Agenda for Change (AfC) and the 3.25% pay increase for employees covered by Executive and Senior Posts (ESP).

10.6.2 Percentage Changes	2024-25 to 2025-26	2023-24 to 2024-25
% Change from previous financial year in respect of Chief Executive	%	%
Salary and allowances	2.7	8.7
Performance pay and bonuses	0	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	2.7	8.7
Performance pay and bonuses	0	0
Average % Change from previous financial year in respect of employees taken as a whole		
Salary and allowances	2.2	7.8
Performance pay and bonuses	0	0

The 2023/24 figures were provided in accordance with the guidance at the time however this did not take into account the 2024/25 Manual for Accounts guidance, which was applied in 2024/25 only. As per the Manual for Accounts, 2025/26 has reverted to the methodology used in 2023/24, whereby the amounts included are following salary sacrifice deductions.

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 2024/25 guidance. The 2.7% reported in 2025/26 is the result of a new Chief Executive and the pay award received.

In terms of the average pay per FTE, the 7.8% reported in 2024/25 relates to the agreed pay increases across the organisation, with salary sacrifice schemes excluded as per the 2024/25 guidance. The 2.2% reported in 2025/26 is the result of the pay award received.

Salary and pensions entitlements of senior managers

Remuneration

A) Remuneration

Name and Title	2025-26 Salary £000 (bands of £5000)	2025-26 Salary FTE £000 (bands of £5000)	2025-26 Benefits in Kind £ Rounded to the nearest £100	2025-26 Pension benefits £000 (Bands of £2500) (Note 20)	2025-26 Total £000 (bands of £5000)	2025-26 Total FTE £000 (bands of £5000)	2024-25 Salary £000 (bands of £5000)	2024-25 Salary FTE £000 (bands of £5000)	2024-25 Benefits in Kind £ Rounded to the nearest £100	2024-25 Pension benefits £000 (Bands of £2500) (Note 20)	2024-25 Total £000 (bands of £5000)	2024-25 Total FTE £000 (bands of £5000)
Colin Dennis (Chair)	40-45		-		40-45		40-45		2,000		45-50	
Kevin Davies (Non Executive Director) (Note 1)							0-5		100		0-5	
Anoop Joga Singh (Non Executive Director) (Note 2)							0-5		-		0-5	
Bethan Evans (Non Executive Director)	5-10		400		5-10		5-10		100		5-10	
Ceri Jackson (Non Executive Director / Vice Chair) (Note 3)	20-25		900		20-25		20-25		1,100		20-25	
Hannah Rowan (Non Executive Director)	5-10		100		5-10		5-10		-		5-10	
Peter Curran (Non Executive Director)	5-10		100		5-10		5-10		100		5-10	
Jayne Beeslee (Non Executive Director) (Note 4)	5-10		400		5-10		5-10		200		5-10	
Rhiannon Beaumont-Wood (Non Executive Director) (Note 5)	5-10		400		5-10		0-5		100		0-5	
Hayley Hutchings (Non Executive Director) (Note 6)	5-10		500		5-10		0-5		200		0-5	
Emma Wood (Chief Executive) (Note 7)	95-100		-	30-32.5	125-130							
Jason Killens (Chief Executive) (Note 8)	50-55		700	92.5-95	145-150		175-180		1,400		175-180	
Christopher Turley (Executive Director of Finance & Corporate Resources) (Note 9)	125-130		1,500		125-130		130-135		300	27.5-30	160-165	
Edward Roberts (Acting Director of Finance) (Note 10)	30-35		500	20-22.5	55-60							
Angela Lewis (Director of Culture Change) (Note 11)	75-80	120-125	-	17.5-20	90-95	140-145	95-100	115-120	-	25-27.5	120-125	140-145
Liam Williams (Executive Director of Quality and Nursing) (Note 12)	145-150		-	122.5-125	265-270		130-135		-	10-12.5	140-145	
Estelle Hitchon (Director of Partnerships & Engagement / Interim Executive Director of Strategy, Planning & Performance) (I	115-120		-	50-52.5	170-175		110-115		-	40-42.5	155-160	
Rachel Marsh (Executive Director of Strategy, Planning & Performance / Interim Chief Executive) (Note 14)	130-135		1,100	170-172.5	305-310		115-120		700		115-120	
Lee Brooks (Executive Director of Operations) (Note 15)	125-130		2,200	35-37.5	160-165		120-125		1,500	32.5-35	155-160	
Jonathan Sammut (Director of Digital Services (Note 16)	110-115		3,900		115-120		110-115		3,700		110-115	
Andrew Swinburn (Executive Director of Paramedicine) (Note 17)	145-150		2,600	235-237.5	385-390		120-125		1,700	22.5-25	145-150	
Carl Kneeshaw (Director of People) (Note 18)	120-125		-	30-32.5	150-155		45-50		-	10-12.5	60-65	
Patricia Mills (Director of Corporate Governance / Board Secretary) (Note 19)	115-120		1,100	30-32.5	150-155		105-110		-	27.5-30	130-135	

Note 1 - Kevin Davies left the Trust on 30th September 2024

Note 2 - Anoop Joga Singh left the Trust on 31st August 2024

Note 3 - 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 4 - Jayne Beeslee joined the Trust on 19th August 2024

Note 5 - Rhiannon Beaumont-Wood joined the Trust on 11th November 2024 and left the Trust on 8th February 2026. Salary full year equivalent is 5-10 (bands of £5000)

Note 6 - Hayley Hutchings joined the Trust on 11th November 2024

Note 7 - Emma Wood joined the Trust on 1st October 2025, with pension contributions from 22nd October 2025 due to an overlap in employments. Salary full year equivalent is 190-195 (bands of £5000)

Note 8 - Jason Killens left the Trust on 18th July 2025. Salary before a salary sacrifice of £2,748 was 55-60 (bands of £5000). Salary full year equivalent before salary sacrifice was 190-195 (bands of £5000). 2024-25 salary before a salary sacrifice of £9,501 was 185-190 (bands of £5000)

Note 9 - Christopher Turley's salary before a salary sacrifice of £8,312 was 135-140 (bands of £5000). 2024-25 salary before a salary sacrifice of £2,078 was 130-135 (bands of £5000) including £2,518 in terms of annual leave sold

Note 10 - Edward Roberts was appointed Acting Director of Finance between 9th September 2025 and 7th January 2026. Salary before a salary sacrifice of £3,757 was 35-40 (bands of £5000). Salary full year equivalent before salary sacrifice was 110-115 (bands of £5000)

Note 11 - Angela Lewis' role changed from Director of People & Culture to Director of Culture Change from 1st November 2024 on a 0.6 WTE basis (22.5 hours). Salary includes £1,413 in terms of annual leave sold. Salary full year equivalent is 120-125 (bands of £5000)

Note 12 - Liam Williams received a pay increase with effect from 1st June 2025

Note 13 - Estelle Hitchon was appointed Interim Executive Director of Strategy, Planning & Performance between 19th July 2025 and 30th September 2025. Salary full year equivalent was 120-125 (bands of £5000). Estelle's salary includes £2,233 in terms of annual leave sold. 2024-25 salary included £2,162 in terms of annual leave sold

Note 14 - Rachel Marsh was appointed Interim Chief Executive between 19th July 2025 and 30th September 2025. Salary full year equivalent before salary sacrifice was 185-190 (bands of £5000). Rachel's salary before a salary sacrifice of £5,006 was 135-140 (bands of £5000) including £2,355 in terms of annual leave sold. 2024-25 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

Note 15 - Lee Brooks' salary before a salary sacrifice of £10,314 was 135-140 (bands of £5000). Pay increase with effect from 4th December 2025. 2024-25 salary before a salary sacrifice of £10,415 was 130-135 (bands of £5000)

Note 16 - Jonathan Sammut's salary before a salary sacrifice of £16,974 was 125-130 (bands of £5000). Pay increase with effect from 13th March 2026. 2024-25 salary before a salary sacrifice of £14,689 was 125-130 (bands of £5000)

Note 17 - Andrew Swinburn salary before a salary sacrifice of £11,555 was 155-160 (bands of £5000) including £3,131 in terms of annual leave sold. Pay increase with effect from 1st June 2025. 2024-25 salary before a salary sacrifice of £11,555 was 135-140 (bands of £5000) including £2,552 in terms of 2024-25 annual leave sold and £2,430 in terms of 2023-24 annual leave sold

Note 18 - Carl Kneeshaw joined the Trust on 1st November 2024, with pension contributions from 4th November 2024 due to an overlap in employments

Note 19 - Patricia Mills' salary before a salary sacrifice of £5,456 was 120-125 (bands of £5000) including £8,560 in terms of lieu of annual leave. Pay increase with effect from 1st August 2025

Note 20 - 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 21 - Payments to past directors Claire Vaughan and Andrew Haywood were made in 2024/25 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 22 - Benefit in kind includes home to work travel and business miles for the Non Executive Directors, and company car for the Directors

Note 23 - Salary for the Chair and Non Executive Directors includes the new fee structure from 1st January 2026

Pension benefits

Name and title	Accrued pension at pension age as at 31/3/26 and related lump sum (bands of £5,000)	Real increase in pension and related lump sum at pension age (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2026	Cash Equivalent Transfer Value at 31 March 2025	Real increase in Cash Equivalent Transfer Value
	£'000	£'000	£'000	£'000	£'000
Emma Wood (Chief Executive) *	40-45	0-2.5	631	551	24
Jason Killens (Chief Executive)	75-80 plus lump sum of 185-190	2.5-5 plus lump sum of 7.5-10	1,664	1,312	92
Christopher Turley (Executive Director of Finance & Corporate Resources)	60-65 plus lump sum of 155-160	0-2.5 plus lump sum of 0	1,425	1,382	3
Edward Roberts (Acting Director of Finance)	20-25 plus lump sum of 50-55	0-2.5 plus lump sum of 0-2.5	431	358	18
Angela Lewis (Director of Culture Change)	5-10 plus lump sum of 0-5	0-2.5 plus lump sum of 0	140	113	16
Liam Williams (Executive Director of Quality and Nursing)	50-55 plus lump sum of 115-120	5-7.5 plus lump sum of 10-12.5	1,117	953	129
Estelle Hitchon (Director of Partnerships & Engagement)	35-40 plus lump sum of 105-110	2.5-5 plus lump sum of 2.5-5	953	867	56
Rachel Marsh (Executive Director of Strategy, Planning & Performance)	65-70 plus lump sum of 75-80	7.5-10 plus lump sum of 7.5-10	1,243	1,044	165
Lee Brooks (Executive Director of Operations)	45-50	2.5-5	692	639	26
Jonathan Sammut (Director of Digital Services) **	-	-	-	-	-
Andrew Swinburn (Executive Director of Paramedicine)	60-65 plus lump sum of 160-165	10-12.5 plus lump sum of 25-27.5	1,459	1,166	256
Carl Kneeshaw (Director of People) ***	5-10	0-2.5	84	53	15
Patricia Mills (Director of Corporate Governance / Board Secretary)	10-15	0-2.5	198	155	26

*Emma Wood paid pension contributions from 22nd October 2025 due to an overlap in pensionable employments
** Jonathan Sammut chose not to be covered by the pension arrangements during the reporting year
*** Carl Kneeshaw paid pension contributions from 4th November 2024 due to an overlap in pensionable employments

Staff Report

Staff numbers

An analysis of staff numbers by category during 2025/26 are set out below. The figures relate to the average number of employees under contract of service in each week of the financial year, divided by 52 (and rounded to nearest WTE).

These figures have been calculated to include inward secondments and agency staff and to reconcile with the financial accounts.

Category	2025/26	2024/25	2023/24
Additional clinical services	1,957	1,974	2,070
Professional, scientific and technical	2	3	3
Administrative, clerical and board Members	760	690	634
Allied health professionals	1,199	1,162	1,103
Estates and ancillary	70	65	58
Medical and dental	1	1	1
Nursing, midwifery registered	219	196	192
Students	0	0	
Healthcare scientists	0	0	
Total	**4,208**	**4,091**	**4,061**

Staff composition

An analysis of the number of persons of each sex who are senior managers of the Trust as at 31 March 2026, are set out below (excludes secondees out of the Trust). This compares to a Trust wide staff composition of 52% female, 48% male.

Gender	Headcount	%
Female	10	55.6
Male	8	44.4
Total	**18**	**100**

Sickness absence data

	2025/26	2024/25	2023/24
Days lost (long term)	92,024.32	85,949.54	93,684.07
Days lost (short term)	29,003.31	30,280.98	32,961.72
Total days lost	**121,027.62**	**116,230.52**	**126,645.79**
Total staff years	349.38	338.88	338.43
Average working days lost	18.05	17.86	19.43
Total staff employed in period (headcount)	4,519	4,381	4, 354
Total staff employed in period with no absence (headcount)	1,365	1,262	1, 025
Percentage staff with no sick leave	**30.07%**	**28.65%**	24.93%

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 Trust policy and procedures continues, and the Trust remains broadly aligned with trends across the wider UK ambulance sector.

Sickness absence data reported in the 2024/25 annual report was reported as 7.35%, however this is now corrected to 7.47%. The same sickness absence figure is recorded for March 2026 i.e. 7.47%.

The performance report at part 1 of this annual report sets out the improvements that have been put in place during the 2025/26 year, and which continue to be pursued to ensure there is a focus on reducing sickness absence.

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 2025/26 the Trust has continued to develop, review, and update several policies in partnership with trade union 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

Disability Confident employer

As a disability confident employer, we are committed to providing an inclusive and fair recruitment process that ensures disabled applicants are considered equitably for employment.

Applications are shortlisted anonymously, with recruiting managers not made aware of any declared disabilities until the shortlisting stage has been completed, ensuring that decisions are based solely on skills, experience, aptitude and ability and helping to reduce the risk of unconscious bias.

In line with our commitment to the Disability Confident Scheme, we operate a Guaranteed Interview Scheme, offering an interview to disabled applicants who meet the essential criteria for the role. Candidates are encouraged to disclose a disability or long-term health condition so that appropriate reasonable adjustments can be put in place at interview and assessment stages, supporting individuals to demonstrate their full potential.

Speaking Up Safely

As indicated in the performance report, the Trust continues to strengthen its Speaking Up Safely arrangements as part of its commitment to an open, supportive culture where all staff feel empowered to raise concerns. The 2025 Staff Survey demonstrated a positive shift in staff confidence to raise concerns, with colleagues reporting that they feel safer speaking up and more assured that issues raised will be taken seriously and addressed appropriately.

Over the past year, the service has expanded from a single Lead Guardian in June 2024 to a dedicated team of three, including an additional Guardian and a Project Support Manager. This increased capacity has enabled a stronger focus on raising awareness of the various channels that can be used to raise concerns and an improvement in the timeliness of responses to concerns raised. There has also been far more engagement with leaders across the organisation and colleagues in key areas of the business including safeguarding to ensure there is an opportunity to listen, respond, reflect and learn from themes that have been identified. This expansion reflects the Trust's ongoing commitment to encouraging an open, supportive culture where all staff feel empowered to speak up.

Strategic equality objectives

The Trust continues to make good progress against its Strategic Equality Objectives by embedding equality, diversity and inclusion principles across Trust plans, policies and everyday practice. Over the past year, notable progress has been delivered across a number of priority areas:

- *Sexual safety, misogyny and violence against women and girls*
  As part of a Trust-wide awareness-raising campaign to prevent sexual harassment in the workplace, training has been rolled out to staff, including bespoke provision for ambulance sector staff and senior management teams. This training supports individuals to identify sexual harassment and challenge inappropriate behaviours confidently and appropriately. During the year, the Trust formally adopted the All-Wales Anti-Sexual

Harassment Policy and is actively contributing to the development of the national implementation plan through collaboration with the All-Wales People Network.

- *Allyship and active bystander training*
  The Trust has continued to deliver its Allyship and Active Bystander Training to staff and volunteers, reinforcing expected behaviours and supporting a more inclusive organisational culture. Feedback from participants remains consistently positive, with clear examples of staff demonstrating effective active bystander behaviours in the workplace. During the year, this training has also been embedded into corporate induction for new starters to support inclusive behaviours from the point of entry into the Trust. In addition, shorter, targeted modules focusing on specific aspects of inclusion have been incorporated into clinical training days.

- *People Networks and our volunteers*
  Engagement in the Trust's People Networks continues to grow, with almost a quarter of the workforce now involved. This year, three new networks have been established: the Military Network, Dementia Champions Network and Faith Network. People Networks have evolved into self-led groups, driven by individuals who are passionate about raising awareness and improving workforce experience. The Inclusion, Culture and Wellbeing Team continue to provide governance oversight and facilitate cross-network collaboration.

  Throughout the year, People Networks have delivered a wide range of impactful initiatives including:
  - bespoke women's health sessions focussing on hormonal health and menopause
  - support for the National Uniform User Group to encourage more accessible and better fitting uniforms
  - Black History Month celebrations where staff had the opportunity to learn about the lived experience of some key individuals who have overcome challenges in the past to improve the lived for future generations of ethnic minority communities within Wales
  - development of a new Health and Wellbeing Passport for employees to record individual needs and help managers identify appropriate support and reasonable adjustments
  - focus groups to help the Digital Team learn more about how to improve digital accessibility for our workforce and service users

- partnership working with the AACE LGBT Network to develop an information resource to educate ambulance service staff on providing better care to people living with HIV. The Trust has linked with Fast Track Cymru to run a workshop for WAST staff around HIV awareness, preventative medication such as PrEP and PEP, the U=U campaign and the ambition to end HIV transmission in Wales by 2030
- preparation to revalidate our Gold Employer Recognition Scheme Award to further enhance our commitment to Armed Forces Communities. This includes building bridges into the workplace for Veterans and supporting our employees who are reservists and Cadet Instructors to help balance their work with their ongoing commitments to the Armed Forces.

- *Financial wellbeing*
  Recognising the pressures of the current economic climate and the impact this can have on mental health and wellbeing, the Trust has continued to support staff through a range of salary sacrifice schemes. Specialist external organisations have also been invited into the Trust to provide education and guidance on financial wellbeing. Alongside this, the Trust has worked with NHS Pensions and NHS Employers to promote information and resources to support staff in planning for retirement.

- *Inclusive recruitment*
  The Trust successfully implemented an inclusive recruitment initiative within the Digital Directorate, which resulted in a significant increase in applications and appointments from candidates from Black, Asian and Minority Ethnic backgrounds. The initiative also led to increased diversity among other successful applicants, including Welsh speakers, LGBTQ+ applicants and people with disabilities. Building on this success, the Trust is now expanding the approach within its contact centres, where there is ongoing recruitment for call handler vacancies.

- *Conferences and events*
  Throughout the year, the Trust has actively engaged in regional and national conferences and events to share learning and adopt best practice in support of its Strategic Equality Objectives. Attendance at events such as Pride Cymru, the Big Halal Expo, Cardiff Mela, the Women's Health Conference, the Anti-Racist Wales Public Sector Leadership Conference, and the NHS Confederation Diversity in Health and Care Partnership has enabled meaningful engagement with service users and stakeholders. These insights continue to inform Trust planning and decision-making. The Trust also hosted the health

zone at the Mastering Diversity event in Cardiff for the second consecutive year, showcasing progress and strengthening networks to further enhance service accessibility and inclusivity.

Further information on the progress made against our Strategic Equality Objectives can be found in our Strategic Equality Plan Annual Report.

Education and development

Education and development in WAST stives to be an inclusive, neuro-affirming experience for colleagues; actively working toward being a Learning Organisation. We have invested in an Essential Skills team to ensure specialist educational support is available to colleagues that works with their professional commitments and develops the skills required to successful develop throughout their working lives. All those involved in the delivery of education are encouraged to develop their educator skill set through a bespoke Education Programme leading to Registration with the Education Workforce Council - this is a requirement for all those delivering regulated qualifications such as our expanding Apprenticeship offer. Learner experience is central to the design, development, delivery, and evaluation of programmes to ensure evidence based and value add can be demonstrated and the impact of learning felt in practice and increased productivity. Colleagues enjoy clear and accessible information about their current learning, pathways on offer and individualised support to assist them plan their careers via a dedicated SharePoint site - Your Best - as part of Our WAST Way People & Culture offer. More on this can be found in the performance report in part 1 of this annual report.

Expenditure on consultancy

Expenditure during 2025/26 in respect of consultancy costs was £715,045 (in 2024/25 it was £583,645.36) across the following areas:

£54,500	Organisation and change management
£128,284	Human Resource, training and education
£92,743	Property and construction
£408,718	Strategy
£30,800	Finance
£715,045	

Expenditure on temporary staff

Expenditure during 2025/26 in respect of temporary staff costs was £0.957m (2024/25 £1.407m). The decrease of £0.450k is largely due to reduction of digital agency staff in post on a non-recurrent basis to assist in the delivery of agreed IMTP deliverables during 2024/25.

Off-payroll engagements

The Trust has a nil return in 2025/26 for off-payroll engagements. This is consistent with that reported in 2024/25.

Exit packages

The Trust has a cost of £330,336 in 2025/ 26 for eight staff exit packages. This compares to a cost of £164,365 in 2024/25. Exit packages are described in Note 10.5 within the financial statements.

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 2025/26 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 2025/26 accounts. This is consistent to that reported in 2024/25.

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 2026 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 2026 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 Minsters' 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 Report, Accountability Report or the Governance Statement.
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 Ass 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
26 June 2026

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

PART 3:

FINANCIAL STATEMENTS

Archwilio Cymru
Audit Wales

Audit of Accounts Report – Welsh Ambulance Services University NHS Trust

Audit year: 2025-26

Date issued: June 2026

Document reference: 5356A2026



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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 2025-26 Annual Report and Accounts. My team have already discussed these findings with the Executive Director of Finance & Corporate Resources.

My team have substantially completed the audit work as set out in my Audit Plan dated April 2026, 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 2025-26 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 18.

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 the Welsh Ambulance Services University NHS Trust (the 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 significant matters** to report.

See **Audit findings**



There are no **uncorrected misstatements** in the accounts to draw to your attention.

See **Audit findings**



Any 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 **26 June 2026**, which is ahead of the agreed deadline of **30 June 2026**.

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:

Materiality	Reporting threshold (trivial)
Set at 1% of gross expenditure based upon 2025-26 draft financial statements	Set at 5% of materiality
£3.5 million	**£173,000**

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:

Remuneration report	Related party disclosures
The remuneration of senior officers and non-executive directors per the banding category	Related party disclosures with senior officers and non-executive directors
£5,000	£10,000

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 the Trust's financial reporting process. There were no such issues identified during the audit.

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

Audit Director	Gareth Lucey gareth.lucey@audit.wales
Audit Manager	Yvonne Thomas yvonne.thomas@audit.wales
Audit Lead	Sioned Owen sioned.owen@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.

Staff secondment

As disclosed in our Audit Plan, an employee of Audit Wales is on secondment with you. In order to safeguard against any potential threats

to auditor independence and objectivity, the following restrictions apply in line with the Financial Reporting Council's Revised Ethical Standard 2024:

- the secondee will not undertake any management responsibilities; and
- the secondment will be for a maximum of 12 months.

Appendix 1 – Audit risks and outcomes

My Audit Plan set out the risks of material misstatement and irregularity for the audit of the Trust's 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.	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 There is a risk of material misstatement due to fraud in expenditure recognition and as such is treated as a significant risk [PN 10]. Financial pressures and the need to achieve a three-year break-even position create a risk of failure to meet this statutory duty. These pressures increase the risk of bias in management judgements and estimates, and that cut off would not be correctly applied to expenditure incurred around the year end.	The audit team: • substantively tested all material areas of pay and non-pay expenditure; • 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 issues in relation to fraud in expenditure recognition.
Remuneration Report disclosures Changes in senior officer and board member posts during 2025-26 could lead to a risk that these were not appropriately disclosed in the remuneration report, with even low value errors resulting in material misstatements.	The audit team: • understood the movements in the senior management team during 2025-26; • 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; and • ensured that disclosures were complete based on the team's knowledge and were prepared in accordance with requirements.	My audit work identified some misstatements within the Remuneration Report as detailed in **Appendix 2**.

Valuation of property assets The value of property assets recognised in the balance sheet are material estimates dependent on specialist and management assumptions. Property assets are required to be formally revalued every five years as a minimum, with indexation applied in interim years. However, values may fluctuate annually, particularly where refurbishment projects are ongoing and related expenditure is capitalised. There is a risk that the carrying value of assets recognised in the accounts may differ materially from their current value as at 31 March 2026.	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 audit work did not identify any issues in relation to the valuation of property assets.

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 were complete, accurate, consistent with evidence and in accordance with requirements.	My audit work identified an issue regarding the transfer of a figure from the supporting working paper into the disclosure template, as detailed in 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 audit work did not identify any issues in relation to the valuation of provisions.

Capital expenditure There was significant investment in capital projects during 2025-26, with a substantial level of capital expenditure being required in March 2026. There is a risk that capital classified as Assets Under Construction could be materially mis-stated due to judgement in determining capitalised costs and year-end valuation.	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 audit work did not identify any issues in the figures reported for capital expenditure.

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
£1,100 disclosure only	Remuneration and Staff Report – Salary and Pensions Entitlements of Senior Managers table	In the table, the Benefits in Kind figure of £1,100 for one director was omitted, resulting in their total remuneration being incorrectly reported in the £300–£305k band instead of the correct £305–£310k band. The disclosure has now been updated to reflect the correct amounts. These adjustments are self-contained to this table.
Various - disclosure only	Remuneration and Staff Report – Salary and Pensions Entitlements of Senior Managers table	The 2025-26 Manual for Accounts introduced a change requiring pension benefits for senior managers to be disclosed in £2,500 bandings, rather than the £1,000 bandings required in previous years. Pension benefits in the table were initially disclosed to the nearest £1,000 and have since been updated to £2,500 bandings. This matter is consistent with similar presentation issues identified across a number of NHS audits in the current

		year following the change in disclosure requirements. These adjustments are self-contained to this table.
Various - disclosure only	Losses and Special Payments (Note 26)	The Manual for Accounts requires this disclosure note to be presented on a cash basis. Audit testing identified a below trivial error whereby a creditor had been incorrectly included. The Trust subsequently reviewed its working paper and identified that, in a number of cases, year-end creditors from 2024/25 (also below trivial), had been excluded when they should have been included, as they were paid during the year. Consequently, a number of below trivial amendments were required to the note, however, the net impact of these amendments was £14,000. In addition, one case now exceeded the £300,000 disclosure threshold and therefore required separate disclosure in Note 26.2. These adjustments are self-contained to this note.
£2,220,000 disclosure only	Related Party Transactions (Note 33)	Audit testing of Note 33 identified an issue following the transfer of the related party payment to St John Ambulance for 2025-26 from the supporting working paper into the disclosure template. The amount disclosed within this note was £246,000; however, audit procedures confirmed the correct amount in line

		with the underlying working paper was £2,466,000. Whilst the underlying expenditure in the financial statements was correctly recorded, the disclosure note has now been amended to also reflect the correct amount. The adjustment is self-contained to this disclosure note.
Various - disclosure only	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

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 2026 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 2026 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 Minsters' 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 Report, Accountability Report or the Governance Statement.

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
26 June 2026

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

25 June 2026

Representations regarding the 2025-26 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 2026 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;
- 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. There are no non-trivial misstatements within the accounts which remain uncorrected.

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 25 June 2026.

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:	Signed by:
Emma Wood	Colin Dennis
Chief Executive	Board Chair
25 June 2026	25 June 2026

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 latest audit quality report.



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

Supporting you

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

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Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

Archwilio Cymru
Audit Wales

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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

Head of Internal Audit Opinion & Annual Report 2025/26

Welsh Ambulance Services University NHS Trust



Reasonable Assurance

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Report status:	Final
Final report issued:	15 June 2026
Author:	Osian Lloyd, Head of Internal Audit
Audit Committee:	23 June 2026

1. Executive Summary

1.1 Purpose of this Report

The Board of the Welsh Ambulance Services University NHS Trust (the 'Trust' or the 'organisation') 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 Global Internal Audit Standards (GIAS).

1.2 Head of Internal Audit Opinion 2025/26

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 2025/26 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 with 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 'Audit Committee'). In addition, regular audit progress reports have been submitted to the Audit 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 Global Internal Audit Standards.

The Internal Audit Plan for 2025/26, was presented to the Audit Committee in March 2025. Changes to the plan have been made during the year and these changes have been reported to the Audit 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 and 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 Global Internal Audit Standards for 2025/26 subject to the UK Public Sector Application Note. We can state that our service conforms to the IIA's professional standards and to GIAS in the UK public sector.

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 2025/26

Substantial Assurance	• Integrated Medium-Term Plan: Development Process • Manchester Arena Inquiry
Reasonable Assurance	• Risk Management and Board Assurance Framework • Welsh Language Standards • Budget Setting

	• Clinical Equipment • Clinical Model Transformation Programme: Governance Arrangements • Cymru High Acuity Response Unit (CHARU) • Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management • Capacity Management Plan • High Risk Record Policy • Data Management Practices / Devolved Data • Emerging Technology Adoption (draft) • Digital Business Continuity (draft) • Organisational Change • Mandatory In-Service Training • Job Evaluation • Ambulance Replacement Programme • Fire Safety
Limited Assurance	None
Unsatisfactory	None
Advisory/Non-Opinion	• Follow Up of Internal Audit Recommendations

Please note that our overall opinion has also considered both the number and significance of any audits that have been deferred during the year (see section 5.7) 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 GIAS, 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 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 organisation. 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 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 the 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 2025/26 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 GIAS.

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 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 with 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 across other audits as well as addressing the implementation of any outstanding recommendations from previous year reviews.

Basis for Forming the Opinion

The audit work undertaken during 2025/26, and reported to the Audit 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 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 the executive team, 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.

The audit work undertaken during the year provides a consistent picture that governance, risk management and control arrangements are generally well designed and operating effectively, with areas for further strengthening identified across a number of themes.

From the opinions issued during the year, two were allocated Substantial Assurance, and seventeen were allocated Reasonable Assurance. There were no Limited or Unsatisfactory assurance opinions. We have also issued one no-opinion follow up report.

In addition, the Head of Internal Audit considered the impact of the audit assignments planned this year which did not proceed to full audit following preliminary planning work and have been deferred until a future audit year. The reason for change to the audit plan was presented to the Audit 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 the change made to the plan when forming the overall opinion.

The findings demonstrate a consistent pattern across audit areas, with well-established frameworks in place, but further work required to ensure consistent implementation, embedding, and effective assurance. A summary of the findings is shown below. We have reported these using the eight areas of the Trust's activities that we had previously used to structure our strategic and annual operational audit plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken three reviews in this area.

Risk Management and Board Assurance Framework – Reasonable assurance was provided. The Trust has established arrangements for identifying, managing and reporting key risks, supported by effective governance oversight through the Board and its committees. However, the Board Assurance Framework remains in development and requires further refinement to strengthen alignment to strategic objectives and enhance its effectiveness as a strategic tool. While there is good coverage of principal risks, improvements are required to strengthen action tracking, including clearer timescales, timely implementation, and ensuring actions translate into updated controls and assurance.

Welsh Language Standards – Reasonable assurance was provided. The Trust has established positive foundations to support compliance, including clear leadership, a comprehensive policy framework, and a range of initiatives to promote bilingual practice. However, arrangements are not yet fully embedded, with weaknesses in monitoring, oversight and governance. In particular, there is limited evidence of ongoing compliance monitoring, weaknesses in the effectiveness of the Welsh Language Advisory Group, and inconsistencies in the recording and escalation of complaints.

Follow Up of Internal Audit Recommendations – Not rated. The review confirmed that arrangements to track and monitor the implementation of internal audit recommendations are established and operating effectively. Further detail on our approach and findings is set out in Section 2.5.

Strategic Planning, Performance Management & Reporting

We undertook two reviews in this area.

Integrated Medium-Term Plan: Development Process – Substantial assurance was provided. The Trust has established a structured and effective approach to IMTP development, supported by a clear planning framework, stakeholder engagement, and governance arrangements. Minor improvements were identified to further strengthen prioritisation, resource planning, and consistency in the application of planning frameworks.

Clinical Model Transformation Programme: Governance Arrangements – Reasonable assurance was provided. Governance arrangements are established, with defined roles, structured reporting, and programme management processes supporting oversight and delivery of this major transformation programme. However, further development is required to strengthen benefits realisation, milestone tracking, and visibility of programme dependencies, to ensure progress and impact are clearly demonstrated as the programme matures.

Financial Governance and Management

We have undertaken two reviews in this area, both resulting in reasonable assurance. In addition, the audits of accounts payable and procurement processes provided by NWSSP concluded a reasonable assurance opinions (see Section 3).

Budget Setting – The Trust has established sound financial planning and budget-setting arrangements, supported by a structured process, clear alignment to organisational priorities, and appropriate governance oversight. However, improvements are required to strengthen contingency management, financial training for budget holders, and formal accountability arrangements.

Clinical Equipment - Arrangements are in place to support the management and maintenance of clinical equipment, with notable improvements since previous reviews. However, significant weaknesses remain in relation to asset visibility and data

quality, including the absence of a centralised inventory and inconsistencies in maintenance records, which limit effective oversight and lifecycle management.

Clinical Governance and Quality & Safety

We have undertaken two reviews in this area, both resulting in reasonable assurance.

Cymru High Acuity Response Unit (CHARU) –The CHARU model is delivering positive clinical outcomes and is supported by established governance, training, and operational oversight arrangements. However, further work is required to strengthen benefits realisation, ensure consistent oversight of training and competency, and enhance governance through improved operational feedback and representation.

Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management – Governance arrangements are well established, with robust processes in place to support system changes. However, further development is required to strengthen post-implementation monitoring, and improve documentation and tracking of changes, and enhance oversight through more structured review and assurance processes.

The planned audit of Remote Clinical Support was not undertaken and was replaced by the CPAS review to reflecting the increasing scale and importance within the Clinical Model Transformation Programme (see Section 5.7).

Information Governance & Security

We have undertaken three reviews in this area, all of which resulted in reasonable assurance.

Data management practices / Devolved data – Arrangements are in place to support the effective use of data, with positive engagement from staff and a strong intent to use data to support decision-making. However, the absence of a coordinated, organisation-wide approach has resulted in a fragmented reporting environment, inconsistent standards, limited central oversight, and reduced assurance over data quality.

Emerging Technology Adoption (draft) **–** The Trust has set a clear strategic ambition to adopt emerging technologies, including Artificial Intelligence and automation. While governance arrangements, policies, and supporting controls require further development, particularly in relation to formalisation, consistency, and scalability, there is evidence that core controls are in place and operating. This includes emerging governance oversight, controlled access to AI tools, and processes for the development and monitoring of automated solutions. Further strengthening will be required to ensure the framework remains effective as adoption increases.

Digital Business Continuity (draft) –Arrangements are established to support continuity of digital services, including defined roles, escalation processes, and tested incident response arrangements. However, improvements are required to strengthen

disaster recovery planning, ensure alignment of continuity arrangements with business impact assessments, and enhance oversight, testing, and organisational learning processes.

Operational Service and Functional Management

We have undertaken three reviews in this area.

Manchester Arena Inquiry – Substantial assurance was provided. The Trust has taken a proactive and well-governed approach to addressing the recommendations arising from the Inquiry, supported by robust internal reporting, clear accountability, and evidence of meaningful operational improvements. However, further work is required to ensure full training coverage across all staff to support the effective implementation of new arrangements.

Capacity Management Plan – Reasonable assurance was provided. A structured framework and supporting controls are in place to manage non-emergency patient transport demand, with consistent application of eligibility criteria and well-established training arrangements. However, improvements are required to strengthen the consistency and transparency of decision-making, audit trails, and oversight of patient impact and unmet demand.

High Risk Record Policy – Reasonable assurance was provided. Key systems and processes are in place to support the identification and use of high-risk records, with information effectively captured and made available to inform operational decision-making and support staff safety. However, control weaknesses exist in governance and oversight arrangements, reliance on manual processes, inconsistent documentation and notification practices, and weaknesses in review and maintenance of records.

Workforce Management

We have undertaken three reviews in this area during 2025/26, all of which resulted in reasonable assurance. In addition, the audit of the payroll system provided by NWSSP concluded a substantial assurance opinion (see Section 3).

Organisational Change – Arrangements are in place to support the management of organisational change, including an established policy framework and governance oversight. However, improvements are required to strengthen the consistency of application, enhance coordination and resource planning, and embed more structured processes for recording, monitoring, lessons learned, and benefits realisation.

Mandatory In-Service Training – Established arrangements are in place to support staff compliance with statutory and mandatory training requirements. However, improvements are required to strengthen communication of guidance, enhance oversight of training needs, and implement more robust processes to address persistent non-compliance and ensure accountability at line manager level.

Job Evaluation – The Trust has established processes aligned to national requirements for job evaluation, with no backlog identified and core arrangements operating effectively. However, improvements are required to strengthen documentation and audit trails, address resourcing and training gaps within job evaluation panels, and enhance monitoring and reporting of performance against improvement actions.

Capital & Estates Management

This year we have undertaken two reviews in this area, both resulting in reasonable assurance.

Capital assurance: Ambulance Replacement Programme - Arrangements are well established to support the delivery of the vehicle replacement programme, including a clear strategic framework, effective governance, financial control, and delivery within budgets and timescales. However, improvements are required to strengthen documentation, and to enhance strategic reporting and completeness of risk management arrangements.

Estates assurance: Fire Safety – The Trust has established fire safety governance arrangements, supported by improved monitoring, reporting, and increased compliance with fire safety requirements compared to previous reviews. However, weaknesses remain in the consistent application of controls at a local level, including training, documentation, and operational practices, indicating a need to strengthen implementation and assurance across Trust premises.

2.5 Approach to Follow Up of Recommendations

As part of our audit work, we consider progress in implementing agreed actions from our previous reports, particularly those where Limited Assurance was provided, and, where appropriate, high priority findings from Reasonable Assurance reports. In 2025/26, a revised follow-up approach was implemented, as agreed with the Trust. This involved reviewing a sample of recommendations recorded as closed within the audit recommendation tracker, comprising a minimum of 50% of high priority findings and 10% of medium priority findings from 2024/25 internal audit reports, with progress updates provided at each Audit Committee meeting. We also undertook 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 to consider and agree 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 GIAS) and the level of overall assurance that we can give.

The Trust's recommendation tracking arrangements continued to operate effectively during 2025/26. The Corporate Governance Team maintains oversight of the tracker, undertaking review and challenging evidence prior to closure, with outcomes reported to the Audit Committee. Relevant extracts are also reported to Board Committees to support oversight within their remit, with the Audit Committee maintaining overall scrutiny and escalating concerns where necessary. The Trust also implemented an enhanced, more automated tracker system during the year, with support from Digital Health and Care Wales.

We undertook follow-up work during the year to validate a sample of recommendations recorded as closed within the tracker. Our testing confirmed that the majority were appropriately classified as complete, although in some cases additional evidence was required, and one recommendation was identified as not fully implemented and has been reopened. This work provides the Audit Committee with additional assurance regarding the effectiveness and 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.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. 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 2025/26 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 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 2025/26.

2.9 Statement of Conformance

The Welsh Government determined that the Global Internal Audit Standards (GIAS) would apply across the NHS in Wales from 1 April 2025.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with GIAS 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 stated who concluded we 'Fully Conform' with the relevant standards.

The NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audits at the Trust in conformance with the Global Internal Audit Standards and the UK public sector practice note for 2025/26.

Our conformance statement for 2025/26 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2025/26 which will be reported formally in the summer of 2026; and
- The results of the External Quality Assessment.

We have set out, in **Appendix A**, the key requirements of the our service S and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2025/26 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 2025/26.

The Head of Internal Audit has unfettered access to the Chief Executive, Chair of the Audit 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 about 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 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.
Procurement	Reasonable	To review the adequacy and effectiveness of the control arrangements governing Single Tender Actions (STAs) and Declarations of Interest (DOIs).

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
Programme management	Reasonable	To provide assurance over the timely rollout of a sample of digital programmes / projects across Wales and steps taking place to overcome obstacles, challenges and manage the delivery of benefits.
Cyber security	Reasonable	To assess the governance process for cyber security, associated risk statements and the management and delivery of improvement plans.

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's internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Outline scope
Budget management	Reasonable	This review considered the budget management process within the JCC, including procedures, responsibilities and management arrangements.

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 and are summarised in the Velindre NHS Trust 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 Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year.

The audit plan approved by the Committee in March 2025 contained 20 planned reviews. One change was made during the year: at management's request, a review of the Clinical Prioritisation and Assessment Software (CPAS) Group replaced the planned review of Remote Clinical Support, reflecting significant developments within CPAS as part of the Clinical Model Transformation. This change was reported to and approved by the Audit Committee.

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 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 Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2025/26	G	March 2025	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2025/26	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)	90%	v>20%	10%<v≤20%	v≤10%
Report turnaround: time taken for management response to discussion & draft report [15 working days]	G	79% (15/19)	85%	v>20%	10%<v≤20%	v≤10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% (18/18)	90%	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

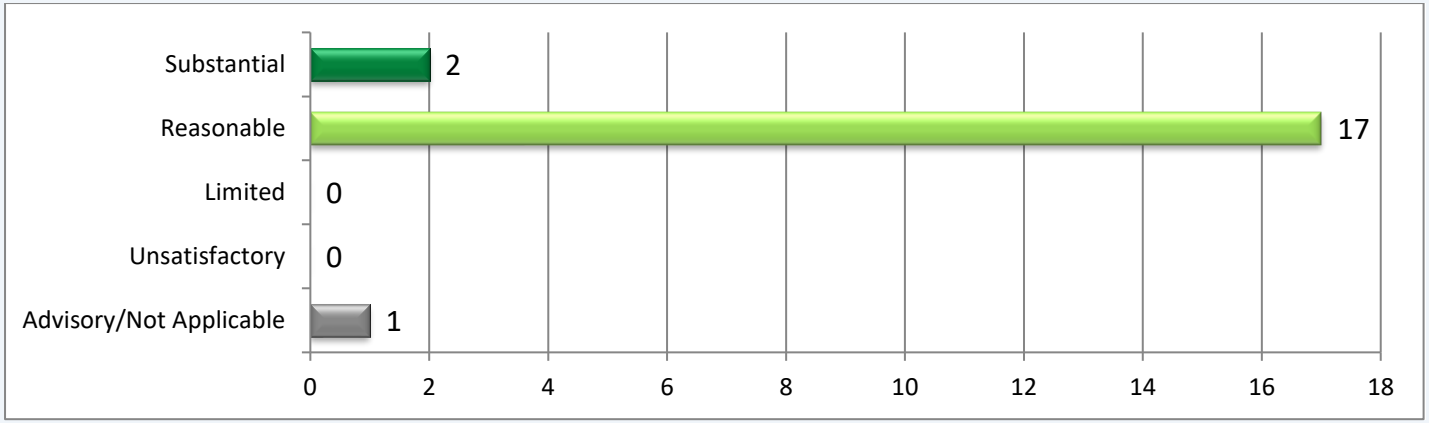


Figure 1 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW or the JCC.

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
Integrated Medium-Term Plan: Development Process	To review the process for developing the Integrated Medium-Term Plan (IMTP), including mechanisms to identify priorities, stakeholder engagement, and alignment to national criteria.

Review Title	Objective
Manchester Arena Inquiry	To review progress in implementing recommendations arising from the Manchester Arena Inquiry; and to assess the governance and reporting arrangements in place, including validation process supporting the closure of actions.

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	To assess the effectiveness of processes for identifying, managing and reporting strategic and key operational risks through the Board Assurance Framework and the Corporate Risk Register.
Welsh Language Standards	To provide assurance on the adequacy and effectiveness of arrangements to comply with the requirements of the Welsh Language Standards.
Budget Setting	To review how the Trust allocates resources to deliver its agreed budget.
Clinical Equipment	To evaluate the effectiveness of arrangements for recording, monitoring and replacing clinical equipment.
Clinical Model Transformation Programme: Governance Arrangements	To review the governance arrangements supporting delivery of the Clinical Model Transformation Programme and its workstreams, including oversight, accountability, and decision-making.

Review Title	Objective
Cymru High Acuity Response Unit	To assess the effectiveness of the Cymru High Acuity Response Unit (CHARU) service in delivering improvements to patient care.
Clinical Prioritisation and Assessment Software Group: Governance and Change Management	To review governance arrangements and operational workflows supporting the Clinical Prioritisation and Assessment Software (CPAS) Group, recognising the increasing scale and complexity of changes managed through this forum in support of the Clinical Model Transformation Programme.
Capacity Management Plan	To assess whether the Capacity Management Plan is applied consistently, supporting effective decision-making and communication with patients.
High Risk Record Policy	This review arrangements for recording, storing and acting upon High Risk Record information to support staff and patient safety.
Data Management Practices / Devolved Data	To assess how data is managed outside the Digital function and whether arrangements support compliance with relevant standards and best practice.
Emerging Technology Adoption (draft)	To assess the robustness of processes supporting the effective, safe, and well-governed use of emerging technologies, including Artificial Intelligence (AI) and automation.
Digital Business Continuity (draft)	To assess the effectiveness of arrangements to maintain service delivery during disruption to digital systems.
Organisational Change	To evaluate the effectiveness of processes for managing organisational change.
Mandatory In-Service Training	To assess the impact and effectiveness of Mandatory In-Service Training (MIST) Days in supporting compliance with statutory and mandatory training requirements.
Job Evaluation	To assess arrangements to comply with the NHS Job Evaluation Handbook.
Ambulance Replacement Programme	To evaluate the effectiveness of arrangements for managing fleet replacement, including value for money, governance and control. This included follow-up of actions from the 2023 Vehicle Replacement Programme audit.

Review Title	Objective
Fire Safety	To assess whether arrangements comply with the Regulatory Reform (Fire Safety) Order 2005, including risk assessments and supporting procedures, and whether previous audit findings have been addressed.

5.4 Limited Assurance (Amber)



No reviews were assigned an 'limited' opinion.

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
Follow Up of Internal Audit Recommendations	To assess whether internal audit recommendations have been effectively implemented and whether monitoring arrangements are effective.

5.7 Audits not undertaken

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Reason why not undertaken
Remote Clinical Support	Replaced at the request of management by the Clinical Prioritisation and Assessment Software (CPAS) Group audit, reflecting significant developments within CPAS as part of the Clinical Model Transformation Programme.

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 2025/26 plan.

Osian Lloyd
Pennaeth yr Archwiliad Mewnol/Head of Internal Audit

Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership

June 2026

Appendix A Conformance

Internal Audit compliance with the Global Internal Audit Standards and the UK Public Sector Practice Note

Global Internal Audit Standards – Domains, Principles & Standards	**Requirements & Response**
Domain I: Purpose of Internal Auditing	Internal auditing strengthens the organisation's ability to create, protect, and sustain value by providing the board and management with independent, risk-based, and objective assurance, advice, insight, and foresight. Advice and assurance are provided primarily through a risk-based audit plan approved and monitored by the Audit Committee. Audit & Assurance uses the results of its audits, together with focused research, to provide insight and foresight.
Domain II: Ethics & Professionalism Principles 1 (Demonstrate Integrity), 2 (Maintain Objectivity), 3 (Demonstrate Competency), 4 (Exercise Due Professional Care), and 5 (Maintain Confidentiality). 13 individual standards.	Audit & Assurance has established processes for dealing with both the ethics and professionalism of Internal Audit and the need to maintain client confidentiality. This encompasses training, declarations of interest returns, our audit processes, and the requirements (where appropriate) of professional accounting and audit bodies.
Domain III: Governing the Internal Audit Function Principles 6 (Authorised by the Board), 7 (Positioned Independently), and 8 (Overseen by the Board). 9 individual standards.	How we interact and work with each NHS Wales organisation is set out in the Internal Audit Mandate and Charter which is updated annually. There are appropriate arrangements in place for Internal Audit to act independently and interact with the Board to ensure effective governance arrangements.

Domain IV: Manging the Internal Audit Function Principles 9 (Plan Strategically), 10 (Manage Resources), 11 (Communicate Effectively), and 12 (Enhance Quality). 16 individual standards.	The Internal Audit function for NHS Wales is managed through the NHS Wales Shared Services Partnership (NWSSP). The Audit & Assurance service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual plan is developed for each NHS Wales organisation. The annual plan gives detail of specific assignments and sets out the overall resource requirement. The audit strategy and annual plan is approved by the Audit Committee. Quality assurance and control arrangements are in place and are subject to an external assessment at least once every five years. Policies and procedures which guide the Internal Audit activity are in place. There is structured liaison with Audit Wales, HIW and Counter Fraud.
Domain V: Performing Internal Audit Services Principles 13 (Plan Engagements Effectively), 14 (Conduct Engagement Work), and 15 (Communicate Engagement Results and Monitor Action Plans). 14 individual standards.	Audit & Assurance has a Quality Manual that sets out how we will conduct and monitor audit engagements and this is then replicated in our Electronic Working Paper system (ESRA) and other files. This ensures that we meet the requirements to plan, conduct and communicate audit engagement appropriately and follow-up management actions.

Global Internal Audit Standards
UK Public Sector Application Note

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

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of 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 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.

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

Global Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms to the Institute of Internal Auditors' professional standards and the Government Internal Audit Standards (GIAS) applicable within the UK public sector.

Follow Up Review

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust



No overall assurance assigned to this work

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Review Reference	WAS-2526-03
Fieldwork	August 2025 to March 2026
Executive Sign Off	9 June 2026
Audit Committee	23 June 2026
Executive Lead	Trish Mills, Director of Corporate Governance
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose and approach

This review assessed whether internal audit recommendations have been effectively implemented. Where revisions to agreed implementation dates have been recorded on the Trust's recommendation tracker, these have been acknowledged and taken into consideration. The review also considered the effectiveness of the systems and arrangements in place to monitor progress with the implementation of actions.

As agreed with the Trust and previously communicated through our progress reports to the Audit, Risk and Assurance Committee (ARAC), a revised follow-up approach has been introduced for the 2025/26 Internal Audit plan year. A minimum of 50% of high priority findings and 10% of medium priority findings from internal audit reports issued during 2024/25 were subject to review throughout the year with updates provided at each ARAC meeting. Selection was based on recommendations recorded as closed within the Trust's recommendation tracker.

The follow-up review does not provide assurance against the full scope and objectives of the original audits, nor does it confirm that all underlying issues have been fully resolved. No overall assurance opinion has been assigned to this work.

Overview

Arrangements within the Trust to track progress against audit findings remain effective although we note that the 'Audit Process and Reporting Handbook' should be revised to incorporate details of the updated tracker processes, including relevant guidance, to ensure alignment with current practice. The arrangements include scrutiny by the Corporate Governance Team prior to the closure of actions on the tracker. Board Committees continue to receive audit reports aligned to their remit and monitor management actions to address recommendations. ARAC also maintains oversight of progress, escalating concerns to the Board where necessary. Where actions reach their final revised implementation date, responsible Directors are required to attend ARAC to provide a clear rationale for delays and outline any associated residual risks.

The Trust implemented the new recommendation tracking system (Audit Tracker 3.0) in December 2025. This SharePoint-based solution, developed with support from Digital Health and Care Wales (DHCW), is intended to improved accessibility, enable real-time collaboration, and enhance data integrity and control, as well as reduce the manual and time-consuming effort previously involved in updating, maintaining and reporting recommendation progress. Quarter 3 represented the first full reporting cycle using the upgraded system with quarter 4 reporting to ARAC planned via a Power BI dashboard. Reporting is expected to continue evolving towards a more streamlined, risk-focused approach, with greater emphasis on highlighting key risks and exceptions and moving away from detailed action listings, supporting clearer, more proportionate and data-driven governance reporting.

Based on our analysis, a total of 97 recommendations were raised in 2024/25, of which 96 were originally due for closure by 31 March 2026. Of these, 72 recommendations have been closed, representing a closure rate of 75%. A total sample of 16 closed recommendations (8 high priority; 8 medium priority) was selected for validation during the year. One of the recommendations (Occupational Health & Wellbeing: Ref 1.1) initially included in the first tranche (implementation dates on or before 31 March 2025), was reopened by management with a revised target date of 31 October 2025. As a result, it was excluded from testing, reducing the final sample to 15 recommendations.

Progress updates were provided at each ARAC meeting, with conclusions from follow-up reviews reported as follows: recommendations due by 31 March 2025 were reported to the December 2025 ARAC; those due by 31 May and 30 September 2025, aligned to Q1 and Q2 updates, were reported to the March 2026 ARAC; and those due by 31 December 2025 (Q3) were reported to the April 2026 ARAC. Recommendations due by 31 March 2026 were included in this review; although six additional recommendations were closed, no further sampling was undertaken as the sample already exceeded the agreed size.

Our testing confirmed that 14 of the 15 recommendations reviewed were appropriately classified as complete on the tracker. However, there were a number of instances where the initial documentation provided to support closure was insufficient, requiring further evidence to be requested; some of which was associated with reports issued under our previous reporting template, in which the 'evidence for implementation' was not explicitly outlined Additionally, while actions were formally closed, further work is planned in some cases to mitigate the associated risks to an acceptable level.

In response to a recommendation raised from our 2022/23 follow up report, a tracker has been developed to capture and monitor Counter Fraud actions. While it had been expected to be presented to the closed session of ARAC from May 2025 onwards, to date it has only been presented in December 2025.

At a glance

The table below sets out the total number of recommendations raised across all reports completed under the agreed 2024/25 Internal Audit plan:

As per original Internal Audit Report					As per audit tracker up to 31 March 2026		
Number of internal audit reports		Recommendations raised			Recommendations closed		
		High priority	Medium priority	Total	High priority	Medium priority	Total
Limited Assurance	4	12	15	27	6	6	12
Reasonable Assurance	13	9	58	67	9	48	57
Substantial Assurance	2	0	3	3	0	3	3
Advisory	1	Whilst actions were raised at this report (Contract Management) they were to be taken forward in partnership with other NHS Wales organisations, including NWSSP Procurement Services, and have not been included on the tracker.					
All reports	**20**	**21**	**76**	**97**	**15 (71%)**	**57 (75%)**	**72 (74%)**

Our analysis of the Trust's quarter four tracker report to ARAC highlights that 73.1% of all internal audit recommendations raised since 2022/23 are recorded as closed (All Wales average[1]: 67.3%), 12.9% are not yet due (All Wales average: 19.7%), with the remaining 13.9% overdue (All Wales average: 12.9%).

In line with the corporate approach to monitoring recommendations, the audit tracker allows for up to two revisions to agreed target dates where management actions are not completed as planned, subject to appropriate justification and approval. Further amendments may be necessary in exceptional circumstances.

The charts below illustrate the application of revised target dates for recommendations raised in 2024–25:

- Chart 1 shows revisions applied to the 72 recommendations closed by 31 March 2026.
- Chart 2 shows revisions applied to the 25 recommendations that remained open at that date.

It should be noted that recommendations still open at 31 March 2026 may be subject to further revisions.

[1] The All Wales average is calculated using the most recent data available within the recommendations database maintained by Audit & Assurance. At the time of reporting, some organisations were still in the process of updating their Quarter 4 data.

Chart 1: Closed recommendations [72]
Revised target dates

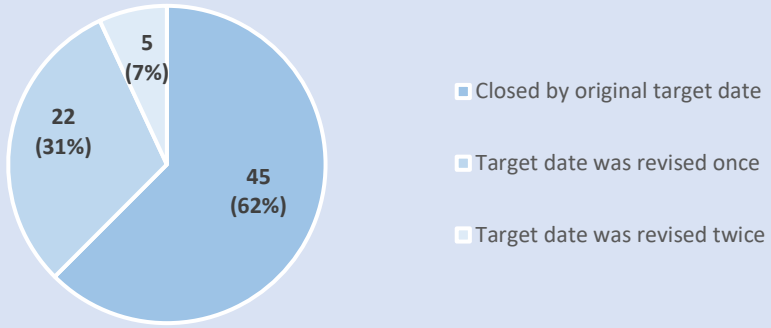
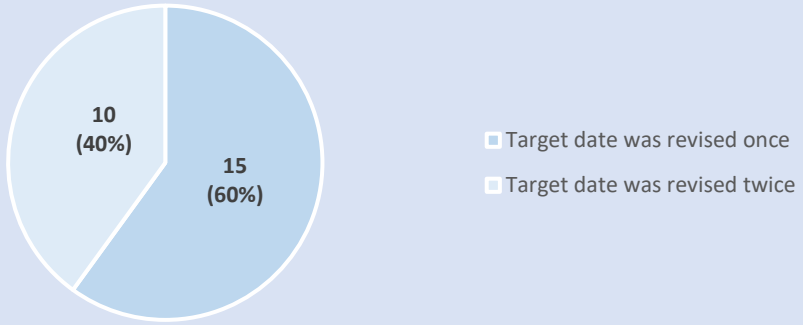


Chart 2. Open recommendations [25]
Revised target dates



The remaining open recommendations relate to 10 internal audit reports, comprising:

Limited assurance (4 reports):

- Resourcing Policy (2 high, 2 medium)
- Vehicle Accident Management (2 medium)
- Start of Shift Procedures (1 high, 2 medium)
- 111 Wales Website (2 high, 4 medium)

Reasonable assurance (6 reports):

- Risk Management (1 medium)
- Overtime Controls (1 medium)
- Emergency Nurse Communication System Implementation (1 medium)
- Occupational Health & Wellbeing Support (1 medium)
- Seasonal Modelling & Forecasting (5 medium)
- Exposure to Fumes (1 medium)

Revised implementation dates for these recommendations range from April 2026 and September 2026.

The table below summarises the sample of closed recommendations (up to 31 March 2026) selected for review from during the year. Full details of testing are provided in the next section: *Progress with prior year recommendations.*

Number of reports included in sample		High priority findings sampled	Medium priority findings sampled	Total findings sampled
Limited Assurance Reports	2	4	-	4
Reasonable Assurance Reports	9	4	7	11
	11	**8** [1]	**7** [2]	**15**

[1] *As per the audit tracker (see Table 1), 15 high priority recommendations had been closed by 31 March 2026; this sample exceeds the 50% requirement set out in our follow-up approach.*

[2] *As per the audit tracker (see Table 1), 57 medium priority recommendations had been closed; this sample exceeds the 10% requirement.*

Corporate approach to tracking recommendations

As previously reported, the Trust has effective arrangements in place to monitor progress in implementing recommendations. The audit tracker is maintained by the Corporate Governance Team, which receives all internal and external audit reports to ensure that all recommendations are captured for reporting to Committees. While recommendations raised from Healthcare Inspectorate Wales have been captured previously, those arising from recent Public Interest Reports issued by the Public Services Ombudsman for Wales are not currently recorded on the audit tracker and this is being explored further.

The Team has produced the 'Audit Process and Reporting Handbook', which contains a section on the audit tracker and sets out the review cycle and responsibilities for associated actions. The handbook states that Directorates are expected to review and update the tracker monthly to support continuous monitoring of progress. It also references the tracker being 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 updates have not been provided. However, ADLT meetings have now ceased, and current tracker guidance indicates that this role has transitioned to the Executive Leadership Team (ELT). The handbook will therefore need to be reviewed and updated to reflect this change. In addition, the handbook should be revised to incorporate details of the updated tracker processes, including relevant guidance and links to the latest tracker documentation, to ensure alignment with current practice.

The Corporate Governance Team also undertake a formal quarterly review of the tracker, examining the evidence provided to support closure of actions before reporting updates to Committees.

Board Committees receive audit reports in line with their remit and monitor the implementation of agreed actions. The ARAC maintains overall oversight, escalating issues to the Board where necessary. Where actions reach their final revised date, responsible Directors are required to attend ARAC to provide them with a clear rationale for delays and any associated residual risks.

Audit Wales' Structured Assessment 2025 (December 2025) recognised the Trust's progress in tracking and monitoring recommendations. These included the development of the new automated audit tracker, which is expected to enhance transparency and Committee oversight. Audit Wales also observed improved performance, with a higher proportion of recommendations closed on time, supported by sufficient evidence and fewer deadline extensions.

The Trust implemented the new tracker system (Audit Tracker 3.0) in December 2025. This SharePoint-based solution, developed with support from Digital Health and Care Wales (DHCW), is designed to improve accessibility, enable real-time collaboration and enhanced data integrity and control, as well as reduce the manual and time-consuming effort previously involved in updating, maintaining and reporting recommendation progress. Quarter 3 represented the first full reporting cycle using the upgraded system, and quarter 4 reporting to ARAC will be presented via a Power BI dashboard. Reporting is expected to continue evolving towards a more streamlined, risk-focused approach, with greater emphasis on highlighting key risks and exceptions and moving away from detailed action listings, supporting clearer, more proportionate and data-driven governance reporting.

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. While this was expected to be presented to the closed session of ARAC from May 2025, to date it has only been presented in December 2025. This included 12 actions, each with agreed deadlines of 1 January 2026 and narrative updates dated October 2025.

Results of Follow-Up Testing on Sampled Recommendations

Resourcing Policy: Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
2.1	**Working Time Breach Review and Reporting Arrangements** Resource Managers should undertake regular review of the Working Time (WT) breach analysis reports, within Global Rostering System (GRS) and ShiftTrack, to identify whether it is a "true" breach and these should be reported.	Service Manager Resourcing November 2024	**High**	A formal process is now in place to support regular review of WT breach analysis reports. The requirement for Resource Managers to undertake monthly reviews of WT breach reports within GRS and ShiftTrack has been embedded into Quality Control and Audit Management processes. Reviews are undertaken to determine whether breaches are "true" breaches, with confirmed breaches escalated to Heads of Service for action. Monthly monitoring is supported by documented process guidance, and evidence of reporting for October–December 2024 was presented to Senior Operations Team (SOT) in February 2025. **Conclusion:** Action implemented as agreed. *Note: one revised target date was applied – 31 March 2025*
2.2	**Working Time Breach Training** Resource Managers should consider whether there is a training need for Resource Co-ordinators or for wherever the WT breach originated e.g. if it was as a result of local arrangements or shift changes.	Service Manager Resourcing November 2024	**High**	Monthly review of WT breach reports is now embedded within established monitoring processes. Resource Managers identify individual, system, or local causes of breaches and agree remedial actions, including training needs, through line management arrangements. Analysis and actions are routinely reported through SOT and Management Team forums. **Conclusion:** Action implemented as agreed. *Note: one revised target date was applied – 31 March 2025*

Vehicle Accident Management: Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
3	**Recording Vehicle Incidents onto Datix** Recording of all vehicle incidents is a requirement of the Trust as outlined in the Driving at Work policy. However, a 12-month comparison (November 2023 – October 2024) between the number of vehicle incidents recorded on DATIX (63) to those recorded / identified on Fleetwave (796) highlights a large discrepancy between the systems, with less than 10% of incidents having been recorded on Datix. Further, noting the expectation of the Driving at Work (DAW) policy for investigations to be recorded on Datix (allowing the root cause of the accident to be identified and to determine any themes or trends), the minimal use of the system does not facilitate this wider understanding.	Head of Service OD June 2025	**High**	Vehicle incident data from Datix and Fleetwave is now routinely reviewed through Local Business Meetings, supported by a dedicated Datix dashboard and documented in Alert, Advice and Assure (AAA) reports. Although system thresholds differ and figures do not align, this is recognised and managed through agreed scrutiny and escalation arrangements. This approach supports identification of themes and trends and improves oversight. **Conclusion:** Action implemented as agreed. *Note: no revised target dates were applied*
4	**Unreported Incidents / Damage** Analysis of the Fleetwave system between November 2023 – October 2024 identified that there is a large number of unreported / unknown damage being recorded on the system. Such are only being picked up once the vehicle is in the workshop for routine checks. Further analysis of the Fleetwave system highlights that a high number of incidents do not have Traffic Accident Report Forms attached to them. Other than those classed as unreported/unknown (145), and therefore would have no completed form, 125 logged incidents/damage have no form. We were informed that this figure would be higher if Fleet did not chase Operations for retrospective forms after identifying damage.	Head of Service OD June 2025	**High**	Unreported and late-reported vehicle damage is now routinely reviewed through Local Business Meetings, supported by ongoing Fleetwave reporting and documented in AAA reports. These forums reinforce expectations for staff to check vehicles at the start of shifts and report damage promptly, addressing issues previously identified during servicing. Increased scrutiny and repeated messaging have improved awareness and oversight. **Conclusion:** Action implemented as agreed. *Note: no revised target dates were applied*

Speaking Up Safely: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
5	**Triangulation of Concerns Data** The SUS Framework defines data points for recording and monitoring individual concerns through the triangulation of lessons learned from closed concerns and the communication of outcomes. However, currently information on all concerns raised through various sources is not collated or reported into a collective document or report for management therefore making it difficult to identify themes or trends and feed learning back to directorates.	Speak Up Safely Lead Guardian May 2025	**High**	The remit of the Speaking Up Safely (SUS) Guardian remains appropriately limited to concerns raised directly through SUS channels, in line with national guidance. It is recognised that not all concerns should be centrally collated, as many are more appropriately managed through established routes such as Patient Safety, People Services, Safeguarding, Equality, Diversity and Inclusion (EDI), or highly confidential Datix processes, and that full consolidation could increase the risk of identification and detriment. Triangulation is achieved through structured thematic recording within SUS, regular multi-disciplinary Lessons Learned forums, quarterly confidential reporting to the CEO, and aggregated annual reporting. This approach supports identification of themes and organisational learning without compromising confidentiality. **Conclusion:** Action implemented as agreed. *Note: one revised target date was applied – 31 October 2025*

Data Quality: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
3.1	**Information Asset Register Accuracy and Governance** Management should ensure that the Information Asset Register accurately reflects the Trust's information landscape to ensure that a singular, consistent catalogue of information assets is in place to monitor compliance and efficiency.	Assistant Director of Digital Services: Data & Analytics April 2025	**High**	Following completion of the internal audit, the Information Governance Steering Group (IGSG) had already agreed to establish an Information Asset Owners Group to support the ongoing development and maintenance of the Trust's Information Asset Register (IAR). An Information Asset Management Group (IAMG) has since been formally established, with approved Terms of Reference setting out responsibilities for the coordination, management, review, and development of the IAR. Evidence confirms that the group is operational and that the IAR is a standing agenda item. While an updated register was not available at the time of review, this is consistent with the agreed action, which focussed on establishing governance arrangements rather than immediate completion of the IAR, and reflects the early stage of implementation. Accordingly, the action is considered to have been delivered as agreed and is suitable for closure, with ongoing oversight provided through established governance arrangements. **Conclusion:** Action implemented as agreed. *Note: one revised target date was applied – 30 September 2025*

Integrated Quality & Performance Management Framework: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
1.1	**Quality & Performance Work Programme Planning** The Quality & Performance Management Framework's work programme should be reviewed and incorporate specific, measurable, achievable, relevant and time- bound (SMART) criteria to define success and provide realistic timescales for delivery. Similarly, any work programmes that are designed to support the pathfinder, e.g. Resource Service, should provide realistic timescales for delivery.	Assistant Director, Commissioning & Performance March 2025	**High**	The Quality & Performance Management Framework work programme has been reviewed and refreshed, incorporating updates following the audit. The revised 2025–28 programme, approved by the Trust Board, includes clearer milestones, defined outcomes, and more realistic delivery timescales. Progress is subject to ongoing oversight through the Q&PMF Steering Group and annual review. **Conclusion:** Action implemented as agreed. *Note: one revised target date was applied – 31 January 2025*
2.1	**Communication Plan Action Planning** The Communication Plan's action plan should be revised to include additional actions pertaining to the later phases. SMART criteria should be incorporated to clarify the current status of actions and provide realistic timescales for delivery.	Assistant Director, Commissioning & Performance December 2024	**Medium**	The Communications Plan has been updated to include actions covering later phases of delivery, now extending to Phase 6. The revised plan provides greater clarity on action status, delivery priorities, and timescales. **Conclusion:** Action implemented as agreed. *Note: one revised target date was applied – 31 January 2025*

Emergency Nurse Communications System Implementation: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
2	**ECNS Audit arrangements** Capacity constraints within the Professional Practice Education (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.	Assistant Director of Operations September 2025	**High**	Capacity constraints have been addressed through implementation of the approved business case to increase PPE staffing. Six ECNS auditors have been recruited in line with the agreed model and an establishment report confirms the increased staffing levels. This uplift provides sustainable capacity to address the audit backlog and support timely completion going forward. **Conclusion:** Action implemented as agreed. *Note: no revised target dates were applied*
8	**Actions to address non-compliance rates** The Integrated Care Quality Group (ICQG) receives a regular Audit and Quality report in relation to ECNS use within Clinical Support Desk (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.	Assistant Director of Operations June 2025	**Medium**	Actions to address ECNS non-compliance have been incorporated into the ICQG governance framework. Actions are formally recorded, assigned to named leads, and monitored through a structured action log, with regular review and escalation embedded within existing assurance processes **Conclusion:** Action implemented as agreed. *Note: no revised target dates were applied*

Exposure to Fumes: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
2.1	**Emergency Department Risk Assessment Programme** The Trust should have a risk assessment work programme in place to ensure that all Emergency Departments (EDs) are risk assessed on a regular basis.	Head of Health & Safety January 2024	**Medium**	A formal risk assessment programme is in place to ensure Emergency Departments are assessed on a regular basis. Risk assessments have been completed or updated across all identified sites. Ongoing review is coordinated through the ED Fumes Task and Finish Group, with defined review frequencies scheduled within the Trust's Health and Safety Management System. **Conclusion:** Action implemented as agreed. *Note: no revised target dates were applied*

Public Engagement and Community Involvement: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
3.3	**Feedback Review and Action Tracking Mechanism** There should be a formal mechanism in place, to confirm that services have reviewed feedback and provide an update of the action taken, where applicable.	Head of Patient Experience and Community Involvement November 2024	**Medium**	A formal mechanism is now in place to ensure services review feedback and take action where appropriate. Feedback is reviewed through the Quality Management Group (QMG), supported by AAA reporting, which evidences service-level discussion and actions Strategic assurance is provided through bi-annual reporting to QuEST, summarising themes, learning, and actions. While action tracking is not yet fully systematised, governance arrangements provide a consistent mechanism for oversight and escalation. **Conclusion:** Action implemented as agreed. *Note: one revised target date was applied – 31 May 2025*

Rollout of Penthrox: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
4	**Reporting / Benefits Realisation** A review of the Board and Committee papers identified a lack of reporting on the use of Penthrox and its effectiveness, training compliance, nor any issues or exceptions relating to its administration. There has been no reporting within the Trust to analyse if the rollout of Penthrox has realised the benefits outlined in the Business Case submitted prior to rollout.	Head of Medicines Management June 2025	**Medium**	The reporting gap has been addressed through the 2024/25 Medicines Management Assurance Report, presented to QuEST in May 2025. This includes detailed analysis of Penthrox usage, training compliance, effectiveness, and exceptions related to administration, supported by tables and appendices. Committee minutes confirm appropriate scrutiny. enabling assessment of whether anticipated benefits have been realised. **Conclusion:** Action implemented as agreed. *Note: no revised target dates were applied.*

Capital Systems: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
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 Royal Institute of British Architects (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.	Head of Capital Development September 2025	**Medium**	A Capital Project Checklist (v0.3) has been developed, establishing a structured approach across RIBA stages and clarifying expectations for key controls and documentation, including declarations of interest, insurance requirements, and contract award notifications. While the checklist remained in draft and full roll-out to Project Managers was not yet evidenced, its development meets the agreed management action. On this basis, the recommendation is considered implemented as agreed and suitable for closure, noting that full embedding will occur through ongoing operational use. **Conclusion:** Action implemented as agreed. *Note: no revised target dates were applied*

Seasonal Modelling & Forecasting: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
6	**Oversight of Forecasting and Modelling activity** The Forecasting and Modelling Group's (FMG) terms of reference note that the "Group will report to the Executive Director of Strategy, Planning & Performance who will determine the subsequent flow of information into the relevant setting." 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.	Assistant Director & Commissioning Performance October 2025	**Medium**	Structured AAA reporting has been embedded within the Forecasting and Modelling Group and Strategy, Planning & Performance governance arrangements, improving visibility and oversight of activity. However, formal reporting of winter modelling into Operations SLT has not been evidenced, and the agreed reporting approach has not been fully implemented. The recommendation was therefore concluded to have been prematurely closed. This has been accepted by the Trust, and the recommendation reopened on the tracker with a revised implementation date of 31 December 2026. **Conclusion:** Not fully implemented – recommendation reopened.

Appendix A: Summary of Status of Findings for Sampled Reports

The following table sets out the status of all findings (based on the Trust's recommendation tracker: 31 March 2026) for reports included in the sample reviewed as part of this exercise:

As per original Internal Audit report:				Sample of closed findings at this review		Status of remaining findings as per tracker (31 March 2026)	
Report title	**Assurance rating**	**High Priority findings**	**Medium priority findings**	**High priority findings**	**Medium priority findings**	**High priority findings**	**Medium priority findings**
Resourcing Policy	Limited	5	4	2	-	Closed: 1 Revised date: 2	Closed: 2 Revised date: 2
Vehicle Accident Management	Limited	3	3	2	-	Closed: 1	Closed: 1 Revised date: 2
Speaking Up Safely	Reasonable	1	4	1	-	-	Closed: 4
Data Quality	Reasonable	2	6	1	-	Closed: 1	Closed: 6
Integrated Quality & Performance Management Framework	Reasonable	3	5	1	1	Closed: 2	Closed: 4
Emergency Nurse Communications System Implementation	Reasonable	2	7	1	1	Closed: 1	Closed: 5 Revised date: 1
Exposure to Fumes	Reasonable	-	7	-	1	-	Closed: 5 Revised date: 1
Public Engagement & Community Involvement	Reasonable	-	6	-	1	-	Closed: 5
Rollout of Penthrox	Reasonable	-	4	-	1	-	Closed: 3
Capital Systems	Reasonable	1	4	-	1	Closed: 1	Closed: 3
Seasonal Modelling & Forecasting	Reasonable	-	7	-	1	-	Closed: 1 Revised date: 5
		17	**57**	**8**	**7**	**Closed: 7 Revised date: 2**	**Closed: 39 Revised date:11**

Appendix B: 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.

Disclaimer

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

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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.

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.



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Shared Services Partnership
Audit and Assurance Services

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

Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management

Final Internal Audit Report

2025/26

Welsh Ambulance Service University NHS Trust



Reasonable Assurance

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Review Reference	WAS-2526-21
Fieldwork	February 2026 - May 2026
Executive Sign Off	10 June 2026
Audit Committee	23 June 2026
Executive Lead	Andy Swinburn, Director of Paramedicine
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

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Audit and Assurance Services

Executive Summary

Purpose

To review the governance arrangements and operational workflows of the Clinical Prioritisation and Assessment Software (CPAS) Group, recognising the high volume and complexity of changes managed through this forum in support of the Clinical Model Transformation Programme, as well as ongoing business as usual activity for the critical 999 and 111 systems.

Overview

In line with the Welsh Government's (WG) strategic vision for healthcare in Wales, including *Together for Health (2011)* and *Achieving Excellence: the Quality Delivery Plan for the NHS in Wales (2012-2016)*, the Welsh Ambulance Services University NHS Trust (the Trust) must continue to improve health outcomes through the ongoing development of high-quality, safe and effective service delivery.

The Trust utilises licensed software systems to support clinically led remote telephone assessments and prioritisation of calls undertaken by non-registrant call-handling staff. These systems include the Medical Priority Dispatch System (MPDS); Emergency Communication Nurse System (ECNS); and Clinical Assessment Software (CAS), which incorporates a call streaming prioritisation functionality and Teleguides (nurse algorithms).

The CPAS Group operates as a key change management forum, responsible for overseeing the quality, clinical integrity and ongoing development of these systems. This includes ensuring that appropriate processes are in place to support system functionality and their effective application in practice, as well the development of clinical guidance, pathways, and improved ways of working. Collectively, this work supports the sustainability and effectiveness of operational delivery across both emergency services (999/MPDS) and Integrated Care services (Clinical Support Desk/111).

The Trust's Dispatch Cross Reference (DCR) table defines the type of clinical response associated with system codes. The CPAS Group has established processes for ensuring safe and consistent maintenance and modification of these response assignments.

Governance arrangements are well established and operating effectively, with clear structures, defined responsibilities and robust pre-implementation controls. In particular, technical testing and approval processes for changes to the DCR Table are robust.

However, the review identified that post-implementation controls are less developed. The absence of structured monitoring, combined with limitations in documentation, tracking and independence of certain controls, reduces overall assurance that changes are consistently embedded and operating as intended.

We have therefore concluded **reasonable assurance** on this area. The following matters require management attention:

- Digitalisation of the change request process to improve completeness, consistency, and auditability.
- Centralisation of DCR change tracking to provide a clear end-to-end view and strengthen oversight.
- Strengthening validation processes to ensure appropriate segregation of duties.
- Development and implementation of a more structured and proactive post-implementation review framework.
- Formalisation of routine review arrangements for DCR changes, supported by updated policy documentation to reflect the expected practices.

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

An additional opportunity for enhancement has been identified in reviewing CPAS Group membership. Given the size of the group, a review would help ensure it remains proportionate and supports efficient discussion and effective decision-making. This observation is highlighted for management consideration and does not impact the overall audit opinion.

Scope & Assurance Summary

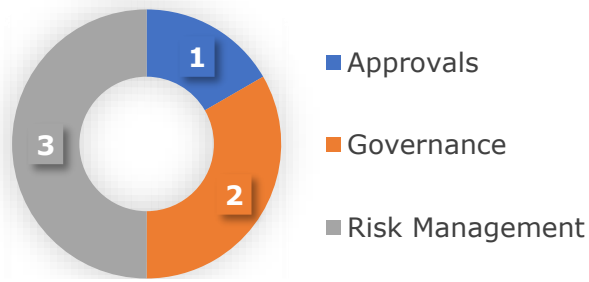
	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	The CPAS Group operates under clear governance with defined roles, responsibilities, decision-making authority, and reporting lines that ensure oversight and escalation.	-	**Substantial**
2	Changes to CPAS systems, pathways, and algorithms are subject to robust change management and clinical assurance to ensure assessment, approval, documentation, and clinical safety prior to implementation.	1 & 2	**Reasonable**
3	Risks from CPAS-related change, including clinical safety, operations and system functionality, are identified, managed, monitored, and escalated in line with the Trust's risk management framework.	3	**Reasonable**
4	Approved changes are implemented consistently, with monitoring to ensure they are embedded as intended and support safe, sustainable delivery across 999 and Integrated Care Pathways.	4	**Limited**
5	The CPAS Group operates transparently with proper documentation and audit trails, enables multi-disciplinary engagement, and aligns with the Trust's strategic objectives and transformation programme.	5	**Reasonable**

Management Actions

1 High Priority

4 Medium Priority

Themes



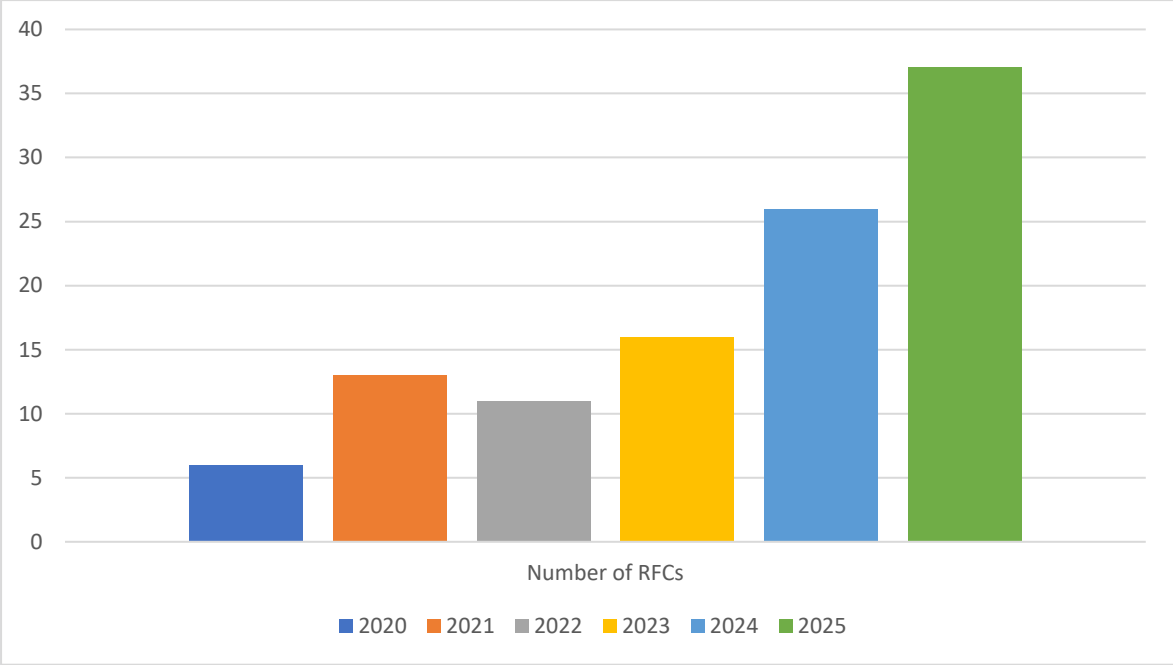
Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

At A Glance: Changes to the Dispatch Cross Reference (DCR) Table

The following chart illustrates the number of requests for changes (RFCs) to the DCR table that have been processed over the last six years, reflecting the increase in recent years primarily owing to the Clinical Model Transformation Programme.



Findings & Agreed Action Plan

Objective 1: The CPAS Group operates under clear governance with defined roles, responsibilities, decision-making authority, and reporting lines that ensure oversight and escalation.	**Substantial**

To ensure the safe and appropriate use of the Medical Priority Dispatch System (MPDS), including determining the clinical response and resources assigned to each of the determinant codes, as set by the International Academy of Emergency Dispatch (IAED), the Trust is subject to both licensing requirements and a clinical duty to operate within a clearly defined governance framework.

Determinant codes are embedded within the Trust's Dispatch Cross Reference (DCR) table. A formal DCR Table Management Policy is in place to ensure the safe and consistent maintenance and modification of clinical response assignments. The policy, available on Siren, was ratified by the Quality, Patient Experience and Safety Committee (QuEST) in April 2024, and is scheduled for review in April 2027.

Key elements of the policy include:

- defined procedures for making changes to the DCR table;
- clearly articulated roles and responsibilities (overall accountability sits with the Executive Medical Director, with delegated responsibility of Accountable Officer placed with the Assistant Medical Director);
- arrangements for audit and monitoring (further considered under objectives 4 & 5).

The CPAS Group operates under an established Terms of Reference (ToR) as a change management forum. Its responsibilities include to oversee and review changes to the Trust's DCR table and to ensure that the assignment of clinical categories and responses reflects best practice and aligns with national standards, including those applied across UK Ambulance Services and Department of Health guidance.

The CPAS Group reports to the Executive Leadership Team (ELT) via the Clinical Quality & Governance (CQG) Group and Senior Operations Team (SOT), providing clear lines of escalation and oversight.

Membership of the CPAS group, as set out in the terms of reference, comprises 27 core members and a further 12 optional attendees, with quoracy defined as a minimum of five members. While it is recognised that certain decisions may require a broad range of expertise, the overall size of the group is comparatively high. Review of meeting minutes from January 2025 to February 2026 demonstrates that meetings were consistently quorate and generally well attended (for example, 26 members in August 2026), reflecting strong engagement. However, consideration should be given to reviewing the membership to ensure it remains proportionate, supports efficient discussion, and enables timely and effective decision-making

Objective 2: Changes to CPAS systems, pathways, and algorithms are subject to robust change management and clinical assurance to ensure assessment, approval, documentation, and clinical safety prior to implementation.	**Reasonable**

Discussions with the Associate Medical Director (CPAS Chair) and Head of Clinical Development (CPAS Vice Chair) confirmed that a structured process is in place for identifying, assessing, approving, and implementing changes to the DCR table. Proposed changes originate from multiple sources, including system updates, new MPDS releases, benchmarking with other UK Ambulance Services, Welsh Government policy changes, and learning arising from Serious Adverse Incidents.

As set out in the DCR Table Management Policy, proposed changes are initially reviewed by the DCR Review Group. Where supported, they are progressed via a Request for Change (RFC) form to the CPAS Group for formal approval. Following approval, changes are subject to system testing by Operations staff before being implemented by the ICT team within the live environment.

We were advised that the volume of changes to the DCR table has steadily increased year on year, primarily attributed to the Clinical Model Transformation programme (see page 3: At A Glance). Of the 37 RFCs approved in 2025, a sample of ten were reviewed. Testing confirmed that, in most cases, the prescribed process is being followed, with appropriate evidence of CPAS approval and completion of RFC documentation.

However, minor control weaknesses were identified in relation to incomplete RFC documentation. Instances were noted where key fields were not fully completed, including submission dates (two cases), identification of accountable officer (five cases) and Support Desk Reference Numbers (one case). While these omissions did not appear to affect the implementation of changes, they highlight reliance on manual processes and increase the risk of incomplete or inconsistent documentation. Digitisation of the RFC would help reduce this risk (see **Key Finding 1**). In one case, a change relating to National Operations Centre (NOC) code updates to new call priorities was implemented by Operations. Whilst it was verbally confirmed that appropriate processes, including testing prior to go-live, were followed, this was not formally evidenced, and ICT involvement was not clearly documented.

Further review identified multiple teams, including CPAS, ICT and Operations, are involved in managing DCR table changes, each maintaining separate and independent tracking mechanisms. While these trackers provide useful visibility at a team level, and support local management of activities, they are not integrated or routinely shared across the end-to-end process. A high-level reconciliation identified inconsistencies between records, indicating that completeness and alignment of change logs cannot be fully assured. As a result, there is no single, centralised view of changes from initiation through to implementation and post-implementation review. This limits overall transparency, coordination, and effective oversight of the change management process (see **Key Finding 2**).

	Key Findings	Risk & Impact	Agreed Management Action
1	**Digitalisation of the Request For Change Process** The current RFC relies on a manual Word-based template to capture and submit change requests. Sample testing identified instances of incomplete documentation, including missing submission dates, unclear assignment of accountability and evidence of testing prior to go-live. While these omissions did not appear to impact the delivery of changes, they highlight a reliance on manual input and review,	Key governance information may be omitted or inconsistently captured, reducing auditability and weakening oversight of changes.	**Agreed Action:** A digital RFC submission and approval workflow (e.g. via an electronic form or system) will be implemented, including mandatory fields, validation controls, and clear assignment of accountability, to ensure completeness and consistency of all change requests.

	Key Findings	Risk & Impact	Agreed Management Action
	increasing the risk of incomplete, inconsistent or non-standard submissions. There is an opportunity to strengthen control design through digitisation of the RFC process, including a review of mandatory fields and validation controls.		**Expected Evidence of Implementation:** • Live digital RFC form/workflow with mandatory fields enabled • Guidance / standard operating procedure for completion and approval • Sample of completed RFCs demonstrating full completion of required fields • System audit trail showing submission, approval, and timestamps
		Medium Priority	**Officer:** Wyn Morris, Interim Assistant Digital Director **Target Implementation Date:** 30 November 2027
	Theme: Information, Data Quality & Data Accuracy	Control Design	
2	**Centralisation of DCR table change tracking** CPAS, ICT, and Operations teams each maintain separate, independent trackers to record and monitor DCR table changes. While effective at a local level, these trackers are not integrated, routinely shared, or formally reconciled across the full process. A high-level reconciliation identified inconsistencies between records (e.g. differences between ICT tracker entries and RFCs provided), indicating that completeness and consistency of change logs cannot be fully assured. This results in the absence of a single, centralised view of all changes, from initiation through to implementation and post-implementation stages.	Limited transparency, potential gaps or inconsistencies in recorded changes, and incomplete oversight across the end-to-end change process may reduce effectiveness of monitoring and control, increasing the risk that changes are not appropriately tracked or managed.	**Agreed Action:** A centralised DCR change tracker (or shared system) will be developed and implemented, which will be accessible to CPAS, ICT, and Operations, providing an end-to-end view of changes from initiation through to post-implementation review. This will include periodic reconciliation between source records to ensure completeness and consistency.
			Expected Evidence of Implementation: • Centralised tracker/system in place with defined ownership • Evidence of use (e.g. populated records covering full lifecycle of changes) • Documented reconciliation process and evidence of periodic reconciliations undertaken • Access permissions showing cross-team visibility • Reporting outputs or dashboards demonstrating improved oversight
		Medium Priority	**Officer:** Wyn Morris, Interim Assistant Digital Director **Target Implementation Date:** 30 November 2027
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 3: Risks from CPAS-related change, including clinical safety, operations and system functionality, are identified, managed, monitored, and escalated in line with the Trust's risk management framework.	**Reasonable**

The RFC form currently includes a field intended for the completion of a risk assessment. However, the Head of Clinical Development advised that there is no formal risk assessment template in use. Instead, risks are considered through discussions at the DCR Review Group prior to approval to proceed to the CPAS Group. Recognising the recommendation to digitise the RFC process (see **Key Finding 1**), this presents an opportunity to review and rationalise the content of the form to ensure that risk information is captured consistently and proportionately within the process.

During the implementation of changes to the DCR table, a number of controls are applied by the ICT team to mitigate risks to system functionality and data integrity. These include:

- Review of data quality and system integrity (e.g. formatting and input accuracy)
- Formal testing in pre-live or training environments
- Validated by Operations prior to go-live Testing procedures are considered robust. The ICT team has developed a comparison spreadsheet that enables users to reconcile between pre-export and post-export versions of the DCR table. This is shared with a defined group of operational staff, who undertake detailed validation to confirm that only intended changes have been applied and that no unintended consequences have arisen. This involved a line-by-line review of the dataset.

There are currently five escalation levels (tables) within the 999 setting and one within the 111 setting. Changes to 999 configurations must be applied consistently across all five tables, with corresponding testing undertaken in each instance. Where errors are identified, changes are returned to the requestor for resolution, and the process is repeated until assurance is obtained.

The ICT team has also established a structured file management system to support the retention and traceability of documentation throughout the change process. Sample testing identified clear and well-maintained records, including RFCs, data files, test outputs, and approval documentation. However, it was noted in some instances that those responsible for requesting the changes are also those validating the testing of changes prior to implementation (see **Key Finding 3**).

Key Findings		Risk & Impact	Agreed Management Action
3	**Segregation of Duties** The review identified that, in some instances, individuals responsible for requesting changes to the DCR table are also involved in undertaking or validating the testing of those same changes prior to implementation. While testing controls are in place and require verification that changes have been correctly applied, this overlap in responsibilities reduces the independence of the assurance process.	Insufficient segregation of duties may reduce the effectiveness and objectivity of testing, increasing the risk that errors or unintended changes are not identified prior to implementation.	**Agreed Action:** Establish and enforce clear segregation of duties within the DCR change process to ensure that individuals requesting or implementing changes are not responsible for undertaking or independently validating testing. This will be supported by defined roles, documented procedures, and oversight controls within CPAS/ICT processes.
			Expected Evidence of Implementation: • Updated process documentation or SOP outlining defined roles and segregation requirements • Testing and validation records demonstrating independent review (e.g. different named individuals) • System/tracker evidence showing role allocation across request, build, and test stages • Sample of completed changes evidencing compliance with segregation of duties
		Medium Priority	**Officer:** Grayham Mclean, Head of Clinical Improvement **Target Implementation Date:** 30 November 2026
	Theme: Approvals	Control Operation	

Objective 4: Approved changes are implemented consistently, with monitoring to ensure they are embedded as intended and support safe, sustainable delivery across 999 and Integrated Care Pathways.	**Limited**

As outlined under *objectives 2 and 3*, there is a well-defined process in place for the identification, approval, and implementation of changes to the DCR table. However, this would be expected to be supported by a formalised and systematic post-implementation monitoring process.

The DCR Table Management Policy states that regular audits should be undertaken by the Emergency Dispatch Quality Improvement Manager to assess the impact of changes to on systems use within the Trust.

However, we note that no formal monitoring arrangements are currently in place to consistently assess whether changes are operating as intended or to evaluate their impact following implementation.

Instead, reliance is placed on contact centre colleagues to identify and escalate issues or anomalies encountered during live call handling (see **Key Finding 4**). While this approach offers valuable real-time operational feedback, we are not aware of this feedback being formally recorded or systematically captured. As such. it is inherently reactive in nature and does not constitute a structured or proactive monitoring control.

The absence of a formal post-implementation review framework limits the ability to gain assurance that changes are embedded effectively and continue to support safe and sustainable service delivery across both 999 and Integrated Care pathways.

Key Findings		Risk & Impact	Agreed Management Action
4	**Monitoring of DCR Table changes** There is currently no structured or documented approach to assess whether approved changes are operating as intended once implemented. Monitoring is reliant on informal and reactive feedback from contact centre staff during live operations, and we are not aware of this feedback being formally recorded or systematically captured. While this approach can highlight immediate issues, it does not provide comprehensive, consistent, or auditable assurance over the effectiveness, impact or sustainability of changes.	Errors or unintended consequences arising from changes may not be identified, recorded or addressed in a timely manner, limiting organisational learning and potentially impacting patient safety, system performance, and operational effectiveness.	**Agreed Action:** Design and implement a structured post-implementation review process for DCR table changes, including defined review criteria, timescales, and responsibilities. This will incorporate routine monitoring, formal capture of operational feedback, exception reporting, and escalation mechanisms aligned to the Trust's risk management framework. **Expected Evidence of Implementation:** • Documented post-implementation review process and completed post-implementation review reports for a sample of changes • Defined KPIs/review criteria (e.g. error rates, call outcomes, incident trends) • Mechanism for recording and tracking operational feedback from contact centre staff • Evidence of issues identified, escalated, and actioned through governance routes • Regular reporting to CPAS and/or relevant governance groups

Key Findings		Risk & Impact	Agreed Management Action
		High Priority	**Officer:** Jonathan Sweet, Head of Service (Operations) **Target Implementation Date:** 30 November 2026
	Theme: Performance Monitoring	Control Operation	

Objective 5: The CPAS Group operates transparently with proper documentation and audit trails, enables multi-disciplinary engagement, and aligns with the Trust's strategic objectives and transformation programme.	**Reasonable**

As noted under objective 2, RFCs outline the requirement for amendments to the DCR table, with the increase in changes largely driven by the Trust's Clinical Transformation Programme. This is captured within the '*why is the work being done*' section of the RFC form, supporting alignment between CPAS activity and the Trust's wider strategic objectives.

The DCR Table Management Policy states that a Clinical sub-group, operating under CPAS, should undertake quarterly reviews of the DCR Table to ensure compliance with IAED requirements and alignment with best practice across UK Ambulance Services. We were advised that the Clinical Sub-Group referenced in the policy is the DCR Review Group. However, discussions with the Head of Clinical Improvement (Chair of the DCR Review Group) confirmed that formal audits are not undertaken in line with policy requirements.

Instead, the group undertakes periodic benchmarking exercises, comparing the Trust's DCR table to those shared by Ambulance Trusts in NHS England. These reviews are typically prompted by updates from the Emergency Call Prioritisation Advisory Group (ECPAG) or the MPDS Academy. While these activities provide a degree of assurance, they are informal in nature, undertaken on an ad hoc basis, and not aligned to a defined schedule or structured audit framework (see **Key Finding 5**).

Outcomes from these reviews are captured in meeting minutes and may result in RFCs where amendments are required. However, the absence of a formalised, documented review process reduces transparency and limits the ability to demonstrate consistent compliance with policy and external standards.

In addition, there is misalignment between policy requirements and current practice. As identified under objective 1, there is also an opportunity to review CPAS membership to ensure it remains proportionate and supports effective decision-making.

Overall, while elements of transparency and alignment are in place, improvements are required to formalise review processes and ensure policy accurately reflects current practice.

Key Findings		Risk & Impact	Agreed Management Action
5	**Routine Reviews of the DCR Table** The DCR Table Management Policy requires quarterly reviews by a Clinical Sub-Group to ensure compliance with IAED standards and alignment with best practice. However, no formal, documented audit activity was identified in line with this requirement. Current oversight is achieved through informal and ad hoc benchmarking exercises, which are not consistently documented or undertaken within a defined review framework.	The absence of formal, structured reviews may result in non-compliance with IAED requirements and reduced assurance that the DCR table remains aligned with best practice.	**Agreed Action:** Establish and implement a formal, documented process for routine review of the DCR table, including defined frequency (e.g. quarterly), scope, and reporting requirements. Update the DCR Table Management Policy to reflect the agreed approach and ensure alignment with current operational practice. **Expected Evidence of Implementation:** • Updated DCR Table Management Policy reflecting agreed review arrangements • Documented review schedule (e.g. quarterly forward plan or standing agenda item) • Completed review reports or documented benchmarking outputs

Key Findings	Risk & Impact	Agreed Management Action
		• Meeting minutes evidencing regular review and discussion, including where no changes are required • Evidence of actions arising from reviews, including linked RFCs where applicable
	Medium Priority	**Officer:** Grayham Mclean, Head of Clinical Improvement **Target Implementation Date:** 30 November 2026
Theme: Information, Data Quality & Data Accuracy	Control Operation	

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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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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Shared Services Partnership
Audit and Assurance Services

Vehicle Replacement Programme

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust



Reasonable Assurance

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Review Reference	WAS-SSU-2526-19
Fieldwork	March - April 2026
Executive Sign Off	26 May 2026
Audit Committee	23 June 2026
Executive Lead	Chris Turley, Executive Director of Finance and Corporate Services
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit.

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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Recognising the Welsh Government's prioritised capital funding provision allocated to the Ambulance Replacement Programme (£20m for 2025/26), this audit evaluated the processes and procedures established by the Trust to support effective management and control of its fleet replacement arrangements. This includes emergency and non-emergency ambulances, as well as specialist support vehicles.

The audit also incorporated follow-up work on previously agreed actions arising from the Vehicle Replacement Programme review undertaken in 2023.

Overview

The Trust is operating under an approved five-year Vehicle Procurement Strategy (VPS), developed through structured engagement with operational staff. Feedback from this engagement has informed vehicle design, procurement decisions, and strategic priorities, with the VPS approved by the Trust Board.

The VPS forms part of a wider fleet modernisation programme running to 2030 and is designed to modernise the fleet, improve vehicle reliability, support clinical transformation, and progress the Trust's decarbonisation objectives. The document sets out a structured, evidence-based investment plan supported by defined governance and financial arrangements, intended to deliver the vision set out in the Trust's Strategic Outline Programme.

The Vehicle Replacement Programme is currently in Year 1 (2025/26) of the five-year VPS and covers Emergency Ambulances (EAs), Solo Responder Vehicles (SRVs), Non-Emergency Patient Transport Service (NEPTS) vehicles and specialist operational vehicles. Alignment with evolving clinical models, including Cymru High Acuity Response Unit (CHARU), Advanced Paramedic Practitioner (APP) roles and growing community-based care pathways, remain key drivers for both the VPS and Vehicle Replacement Programme.

During 2025/26, the Trust planned to procure 142 new vehicles to strengthen frontline operational resilience; with 141 having been procured by the end of the financial year (noting one vehicle was formally withdrawn from the programme). Procurements were delivered through a combination of Crown Commercial Service (CCS) frameworks and competitive tendering routes, with support from NWSSP Procurement Services. The Programme is undertaken in two key stages: (1) acquisition of vehicle chassis from selected manufacturers; and (2) conversion required to meet the Trust's operational specifications. Of the vehicles procured, 56 are operational with the remainder at different stages of build and conversion. Deliveries have intentionally been staggered to reflect capacity limitations at the vehicle workshop, with appropriate contractual arrangements in place for those awaiting delivery and acceptance by the Trust.

Overall **reasonable** assurance has been determined. The processes for managing and requesting funding for vehicle replacement are mature and well understood by programme staff. Governance, financial monitoring and procurement controls are operating effectively, with the Programme currently delivering within budget and agreed timescales. While improvements are required in relation to documentation clarity, strategic reporting and risk completeness, these issues are not considered to undermine the overall effectiveness of programme management arrangements. The matters raised for management attention include:

- A review of the Project Initiation Document (PID) is required to ensure full compliance with PRINCE2 principles, as previously raised and accepted by management in the 2023/24 Vehicle Replacement Programme audit (issued February 2024: reasonable assurance). In particular, the PID does not clearly outline end-stage reporting requirements, nor does it explain how specifications are approved from start to finish, or who is responsible for talking to suppliers, negotiating costs, or agreeing prices; and
- Inclusion within the Business Justification Case of a comparison between investment to date and the Strategic Outline Programme, alongside variance analysis and commentary on vehicle numbers – an area previously raised and accepted by management in the 2023/24 audit report.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. During the course of the audit fieldwork, we also noted that whilst a risk relating to electrical vehicle infrastructure capacity was recorded on the Decarbonisation risk register and the Transport Project Board risk register,

given its alignment with the programme, we would expect it to be captured on the project risk register too. We have highlighted this for management information, and it does not impact the overall opinion.

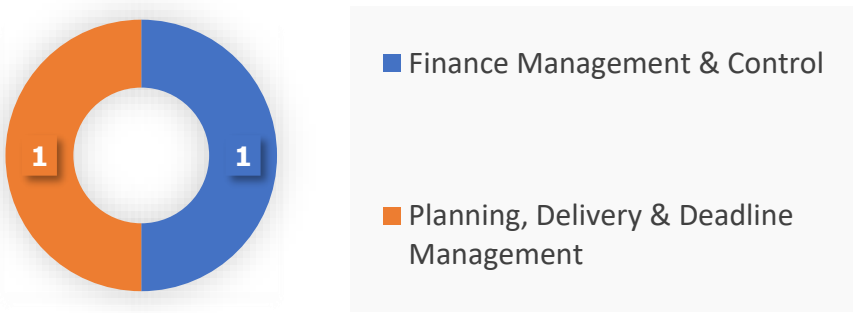
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	There is an established and approved strategy to the overall replacement programme, integrated with the approved Integrated Medium-Term Plans and annual plans. Assurance that decarbonisation and other emerging priorities have been adequately assessed within the strategies.	-	**Substantial**
2	To confirm appropriate programme management arrangements including client defined client requirements, adoption of project management tools, and commissioning arrangements.	1	**Reasonable**
3	The procurement of vehicles (and adaptation) complies with established local and national procurement requirements.	-	**Reasonable**
4	Appropriate financial monitoring and reporting arrangements are in place, including monitoring of in-year expenditure and overall budget.	2	**Reasonable**
5	The previously agreed recommendations (SSU-WAST-2324-01, issued February 2024, reasonable assurance) have been appropriately actioned by management.	1, 2	**Reasonable**

Management Actions

-	2
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Financial Loss

At A Glance: Vehicle Procurement 2025/26

Status of the approved vehicle procurement requirement, as at the date of reporting, is set out in the following table:

Categorisation of vehicle	Required	Procured	Operational	Status of remaining vehicles
Emergency Medical Services (EMS)	44	44	42	2: delivery imminent.
Fleet	3	3	2	1: conversion progressing with delivery imminent.
Occupational Health	2	2	-	2: vehicles have been converted; user training to be progressed before going into service.
Hazardous Area Response Team (HART)	1[1]	-	-	-
Ambulance Care (large)	65	65	-	4: communications installed but some functionality issues with battery management side of the vehicles noted so reconfiguring the parameters and processes to ensure they perform in service. 28: at dealership for pre-delivery inspection and registration. 33: at various stages of build.
Ambulance Care (small)	13	13	-	13: at dealership for pre-delivery inspection and registration and waiting delivery logistics to the commissioning centre.
Rapid Response Vehicle (RRV)	12	12	12	-
Training	2	2	-	2: at dealership for pre-delivery inspection and registration; and dealership fitments.
	142	**141** [1]	**56**	

[1] *The HART command and control vehicle was formally withdrawn from the 2025/26 programme, following approval by the Fleet and Strategic Development Groups (FSDG) – see objective 3.*

Findings & Agreed Action Plan

Objective 1: There is an established and approved strategy to the overall replacement programme, integrated with the approved Integrated Medium-Term Plans (IMTP) and annual plans. Assurance that decarbonisation and other emerging priorities have been adequately assessed within the strategies.	**Substantial**

Strategic Planning and Approvals

The Trust's five-year Vehicle Procurement Strategy (VPS) for 2025-30 was approved by Welsh Government on 31 January 2025. It sets out a needs-led and prioritised programme for vehicle replacement, supporting both fleet sustainability and wider clinical transformation objectives. The Strategy was developed through appropriate engagement with operational stakeholders and aligns with the Trust's Delivery Excellence framework and the IMTP. The VPS responds to evolving Emergency Medical Services (EMS), Non-Emergency Patient Transport Service (NEPTS) and specialist services, including consideration of rural service delivery requirements and evidence-based assessment of fleet reliability risks.

The Year 1 (2025/26) capital requirements were incorporated directly within the VPS, mitigating the need for a separate Business Justification Case (BJC) for that year. Welsh Government approved capital funding of £22.542m on 12 March 2025, to support the replacement of 142 vehicles, with the approval letter stating that the funding is available for drawdown over the period 1 April 2025 to 31 March 2027.

The VPS recognises the need to support ongoing clinical and operational transformation, including expansion of rapid response and Specialist Response Vehicle (SRV) models, enhanced in-vehicle clinical environments, and the development of new and evolving care pathways supporting mental health, falls and frailty, palliative care and rural-based service delivery. It also reflects evolving operational requirements across NEPTS, transfer and discharge services, and specialist operational functions.

An IMTP-led Fleet Review, completed in February 2026, informed vehicle optimisation requirements and design enhancements, including improvements to ergonomics, storage capacity and dementia-friendly features within emergency ambulances. Such are intended to be incorporated into future BJCs submitted to Welsh Government, in line with principles and directions set out within the VPS.

Decarbonisation and Emerging Priorities

Being cognisant that fleet activity accounts for approximately 80% of the Trust's total carbon emissions, the VPS is aligned with the NHS Wales Decarbonisation Delivery Plan 2021–2030 and the Trust's Decarbonisation Action Plan (DAP). The Strategy supports projected emissions reductions of 16% by 2025 and 34% by 2030. Planned investment includes increased deployment of hybrid and electric vehicles, including trials of fully Electric Vehicle (EV) SRVs, expansion of site-based charging infrastructure, and operational practices designed to support Trust-wide carbon reduction targets.

We recognise that significant challenges remain in relation to charging infrastructure capacity across Trust sites. As a result, vehicle relocation is sometimes required to ensure EVs can be accommodated within available charging capacity. This issue is recognised by management as an organisational risk and is intended to be escalated to the corporate risk register following completion and review of EV trial reports. At the time of the audit, this risk was not recorded within the project risk register (see *Objective 2*).

Objective 2: To confirm appropriate programme management arrangements including client defined requirements, adoption of project management tools, and commissioning arrangements.	**Reasonable**

Client Requirements

The process for managing and requesting funding for vehicle refresh is mature and well understood by those involved in the Programme. This includes a clear understanding of whole-life vehicle costs and recognition that maintenance and retention costs increase significantly once manufacturer warranties expire, reinforcing the need for timely replacement decisions.

The Programme is overseen by an experienced National Fleet Manager, with day-to-day operational management of the procurement activity undertaken by a dedicated Project Manager. This is supported by specialist procurement officers and appropriate administrative support, providing a sound governance and delivery structure.

Project Management

Section 4.1 of the Project Initiation Document (PID) for Year 1 (2025/26) of the Vehicle Replacement Programme states that '*WAST will use a tailored project management methodology based on Projects in Controlled Environments (PRINCE2)*', with elements applied as deemed appropriate to the Programme.

A range of core project management controls are in place and operating effectively, providing an appropriate level of oversight. These include an approved project plan, maintained risk, issues and decisions registers, and established reporting and governance arrangements. The programme remains on track, with limited and managed slippage relating to NEPTS Large vehicles and one specialist workshop van conversion.

However, our review of the PID identified that gaps remain in demonstrating full compliance with PRINCE2 principles, consistent with findings raised in the previous audit (see *objective 5 – refs 1.1, 3.1 and 4.2*). Specifically, weaknesses remain in relation to end-stage reporting arrangements, clarity over specification approval processes, and the explicit delineation of roles and responsibilities for commercial and procurement-related decision-making (see **Key Finding 1**).

Risk Management

Review of the project risk register confirmed that, for risks currently captured (predominantly rated as low), appropriate mitigating actions are in place. Ongoing monitoring and oversight are evident, including continued management attention on: (1) ICT capacity and service continuity risks; and (2) residual delivery risks associated with slippage in NEPTS Large vehicles and the specialist workshop van. A risk relating to EV charging infrastructure capacity across Trust sites is not currently captured within the project risk register, representing a gap in formal project-level risk management. However, management has advised that the risk is being managed through the Decarbonisation Programme Board and is expected to be escalated following review of the EV trial outcomes. At present, the risk is recorded on the Decarbonisation risk register, the Transport Project Board risk register and the EV Infrastructure Project RAID (Risks, Assumptions, Issues and Dependencies) log but there is an expectation that the project risk register should reflect the same.

Commissioning

Robust commissioning arrangements are in place. Detailed inspections are undertaken by the Trust's fleet vehicle commissioning officers at the Merthyr Workshop, with engagement from clinical and operational representatives where appropriate, prior to vehicles being formally accepted into service. This ensures required fittings and equipment (for example, straps and fixtures) are consistently installed, minimising the need for remedial work post-delivery. Management advised that serious defects in Emergency Ambulances (EAs) are rare. At the date of reporting, 32 of the expected 44 EAs for 2025/26 had been successfully commissioned and were operational; with the remaining 12 going through the commissioning process.

Key Findings		Risk & Impact	Agreed Management Action
1	**Project Initiation Document (PID) – PRINCE2 Compliance** Review of the PID identified that gaps remain in demonstrating full compliance with PRINCE2 principles, consistent with findings reported in the previous audit. While key parties are identified, the PID does not include a clear, end-to-end specification approval workflow. Management previously agreed to enhance the specification agreement through the development of a visual process map; however, evidence of this has not been provided. In addition, although the PID identifies procurement and project roles and recognises NWSSP Procurement Services as the procurement lead, it does not explicitly define responsibility for commercial dialogue, cost negotiation or supplier pricing discussions. The separation of roles between procurement (commercial responsibility) and project officers (technical responsibility) is implied but not formally documented.	Failure to clearly document approval workflows and delineation of commercial responsibilities weakens project governance and may expose the Trust to avoidable commercial, financial, and assurance risks.	Update the PID to fully align with PRINCE2 principles by: • Documenting a clear, end to end specification approval workflow supported by a visual process map, which defines key stages, roles, approval points, and escalation routes. • Formally defining and documenting roles and responsibilities for procurement and project staff, explicitly distinguishing between commercial responsibilities and technical responsibilities. **Expected Evidence of Implementation:** • Updated version of the PID (2027/28 programme onwards) with explicit inclusion of an end-to-end specification approval workflow; and clearly defined roles and responsibilities for procurement and project staff.
		Medium Priority	**Officer:** Andrea Davies, Project Manager / David Holmes, National Fleet Manager
	Theme: Planning, Delivery & Deadline Management	Control Operation	**Date:** May 2027 (subject to funding approval and associated timescales)

Objective 3: The procurement of vehicles (and adaptation) complies with established local and national procurement requirements.	**Reasonable**

Procurement Approach

Procurement activities for the Vehicle Replacement Programme comprise the sourcing of vehicle chassis and the procurement of fit-out and conversion services across a range of vehicle types. The largest element relates to emergency ambulances, with total conversion and equipment costs of approximately £10.49m, for which the Trust has historically utilised a preferred supplier.

During 2025/26, the Trust planned to procure 142 vehicle chassis through the Crown Commercial Services (CCS) Framework. Of these, 44 chassis were for EMS vehicles. The planned procurement of a Hazardous Area Response Team (HART) command and control vehicle was formally withdrawn from the 2025/26 programme, following approval by the Fleet and Strategic Development Group (FSDG) reducing the number of vehicles to 141. The associated funding was returned to contingency and along with project underspends, enabled the advance purchase of 22 vehicle chassis originally planned for the 2026/27 Vehicle Replacement Programme, secured at 2025/26 prices. This approach mitigated the impact of anticipated inflationary pressures and was approved by both the FSDG in October 2025 and Welsh Government in November 2025.

The Procurement Strategy is based on a purchase-only model. Competitive tendering was pursued for conversion and equipment supply, with appropriate approvals from both the Trust Board and Programme Board in line with delegated financial limits (see objective 5 – ref 5.1). NWSSP Procurement Services led commercial oversight and "All-Wales" procurement elements, providing assurance of compliance with national procurement requirement.

Technical evaluation of bids was undertaken by the Vehicle Working Group, with parallel scoring conducted by NWSSP Procurement Services (see **Key Finding 1**). A combined evaluation outcome was then agreed. Evaluation criteria were applied consistently and transparently in accordance with framework, pre-tender estimates and tender documentation.

For 2025/26, the Trust was already in-contract for EA and SRV conversions. New contracts were competitively tendered and awarded for the conversion of the Ambulance Care / Large NEPTS vehicles. Specialist occupational health vehicles, fleet workshop vehicles, and small NEPTS vehicles were awarded via the national ambulance vehicle conversion framework hosted by Southeast Coast Ambulance Service NHS Foundation Trust (SECAMB). Pre-build meetings were held with successful suppliers to confirm and validate that agreed specifications would be fully met prior to manufacture.

Contracts and Warranties

In light of the high-rated finding raised in the 2023/24 audit regarding contract approval and compliance with Standing Financial Instructions (SFIs) (see *Objective 5 – ref 5.1*), we reviewed the operation of the revised approval arrangements. Purchase Orders relating to all sampled chassis and conversions purchases were evidenced as being approved by Trust Board and Programme Board in line with delegated limits and procurement requirements.

We note that contractors are responsible for the safe storage and insurance cover for the period of time vehicles are at their assigned location until such time that the vehicles are completed, delivered to, inspected and accepted by the Trust.

Chassis warranties are provided through standard manufacturer warranties included under CCS framework agreements, with extended warranties specified within supplier quotations where applicable. Conversion warranties are set out within tender specifications and contract award documentation rather than on individual purchase orders. No significant warranty disputes have been identified in recent periods.

Objective 4: Appropriate financial monitoring and reporting arrangements are in place including monitoring of in-year expenditure and overall budget.	**Reasonable**

The long-term and annual budgets for the Vehicle Replacement Programme were formally approved through business case processes. For 2025/26, Welsh Government agreed an alternative approval approach whereby a separate BJC was not required (see O*bjective 1*). This reflected the maturity of the programme and the prior approval of the overall funding envelope through the VPS.

As reported in our previous audit (refer to *Objective 5 – ref 6.*1), there is an expectation that progress against the Strategic Outline Programme (SOP) is demonstrable, including comparative analysis of planned versus actual vehicle numbers and associated financial values. Review of the 2026/27 BJC confirmed that while it aligns to the VPS and clearly articulates the strategic and operational justification for planned investment, it does not include a stage evaluation of investment to date against the SOP. This limits visibility of cumulative progress and variance analysis (see **Key Finding 2**).

Internal Governance and Financial Monitoring

The Vehicle Procurement Project Team meets on a monthly basis and reviews budget utilisation, forecast spend, supplier quotation, Purchase Order progression, vehicle delivery, commissioning and receipting. This provides operational-level oversight and supports early identification of financial and delivery risks.

A structured contingency is retained within the programme to mitigate identified risks, such as inflationary pressures and specification change. The withdrawal of the (HART) vehicle requirement released funding back into contingency. In addition, WG supported advance purchasing of chassis enabling the Trust to mitigate inflationary risk by securing vehicles at 2025/26 prices.

Monthly reporting to the FSDG provides Programme Board-level oversight and enables ongoing monitoring of expenditure against approved budgets. Delivery of vehicles planned for 2025/26 remain on track, including SRVs, EMS ambulances, NEPTS small vehicles, driver training vehicles, workshop vehicles and Occupational Health vehicles, with increased commissioning activity from February 2026.

As the time of audit fieldwork, FSDG reporting identified two amber-rated areas due to potential delivery slippage: (1) HART responder vehicle (awaiting chassis), subsequently withdrawn from the programme as noted above; and (2) NEPTS Large vehicle conversions, which may extend into the 2026/27 financial year.

Programme financial performance is also reported to the Capital Management Board (CMB) on a bi-monthly basis and to the Capital Management Group on a monthly basis, providing wider corporate oversight of capital expenditure and financial control.

External Oversight

Bi-monthly status reports are submitted to WG and considered through the All Wales Capital Programme meetings, supporting external assurance over in-year monitoring against the approved cost envelope. Cumulative expenditure of £6.757m to January 2026 reconciles to the Capital Resource Limit (CRL), demonstrating that, at the time of review, the Programme remained within approved budget and agreed timescales.

Key Findings		Risk & Impact	Agreed Management Action
2	**Incomplete Strategic Outline Programme (SOP) Variance Analysis** The 2026/27 BJC demonstrates strong alignment with the VPS and clearly articulates the strategic and operational justification for the planned investment. It does not include the expected comparison of cumulative investment to date against the SOP, nor does it provide variance analysis or commentary for planned versus actual vehicle numbers or associated financial values. We recognise, however, that the BJC was approved in November 2025, part way through the 25/26 programme delivery, therefore the full delivery provision was not yet known at that stage. Variance analysis should be appropriately reflected in a programme closure report, alongside an overall assessment of delivery. For transparency, a summary of progress and key variances should then be incorporated into the 2027/28 BJC.	The absence of SOP-level variance reporting reduces transparency over cumulative programme performance and may limit the timely identification and escalation of overspend, underspend, or delivery slippage.	The Trust will continue to ensure that future Project Closure Reports include a clear comparison of cumulative investment to date against the SOP. These will also be considered as part of future BJCs, as appropriate, highlighting where there are any material variances when compared to the VP Strategy (noting that timescales for BJC development and formal Project Closure are not always aligned). **Expected Evidence of Implementation:** • 2025/26 Programme closure report (at which point this action will be closed off the audit tracker). • Revised BJC template / written guidance explicitly including the cumulative investment to date; vehicle numbers (planned vs actual); and financial variance analysis if material and applicable to do so.
		Medium Priority	**Officer:** Andrea Daves, Project Manager / Ed Roberts, Project Accountant **Date:** December 2026
	Theme: Finance Management & Control	Control Design	

Objective 5: The previously agreed recommendations (SSU-WAST-2324-01, issued February 2024, reasonable assurance) have been appropriately actioned by management.	**Reasonable**

The table below summarises the recommendations included in the 2023/24 audit report and the status of each at the date of audit fieldwork. While management has made progress in addressing the majority of recommendations, particularly in relation to procurement strategy, contract approval processes, commissioning arrangements, and articulation of whole-life cost considerations within Business Justification Cases (BJCs). However, evidence provided did not fully support closure for four recommendations that were recorded as closed on the Trust's tracker, relating to project governance, documentation clarity, and strategic performance monitoring.

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Update and Audit Assessment
Project Management (Design)				
1.1	Project controls should be reviewed for appropriate compliance with Prince2 principles, including: • Effective representation of Supplier, Customer, and Executive roles within the project management structure. • Clear delegation of financial tolerances for stage and annual delivery. • Formal end-stage reporting to assess project controls, benefits realised and lessons learned.	Fleet SOP Delivery Group (FSDG) Chair and Project Manager 30 June 2024	**Medium**	**Partially Implemented: Superseded** • Management has confirmed that a robust governance structure is now in place, with clear representation across business, user and supplier roles. • The Trust has taken a deliberate decision, which is explicitly documented within the PID, not to delegate financial tolerances to the Project Manager. Any deviation from approved stage or annual delivery is therefore subject to formal escalation through established governance arrangements. • However, while the PID outlines end-of project reporting arrangements, it does not define the requirements for formal *end-stage* reports in line with the recommendation. In addition, no end-stage reports for 2024/25 were provided as evidence. Management advise that project slippage was experienced and the programme has yet to be formally closed. As a result, we are unable to support the closure of this element of the recommendation at this time (see **Key Finding 1**).
Optimal Procurement Quantity (Design)				
2.1	The benefit of additional vehicle purchases should be contrasted with the associated costs of retaining older vehicles within business justification cases.	Head of Financial Business Intelligence & Capital Planning	**Low**	**Closed** Annual BJCs are now the formal mechanism through which fleet numbers and vehicle types are validated. Review of the approved 2026/27 BJC demonstrates an improved narrative outlining the operational and financial consequences of

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Update and Audit Assessment
		and Project Manager 30 June 2024		retaining older vehicles. This includes high-level modelling of additional revenue costs associated with non-replacement. The BJC also presents and contrasts strategic options which inherently reflect the trade-off between additional vehicle purchases and continued retention. Additionally, the supporting Benefits Realisation documentation provides an economic and operational rationale for replacing over-age vehicles. Consequently, the audit is able to support closure of this recommendation.
User Sign Off (Operation)				
3.1	The process of agreeing vehicle specification should be clearly defined within the Project Initiation Document. This should include involvement of relevant parties such as the Vehicle Working Group and the Project Board, and explicit user sign-off of requirements and minimum performance specifications.	Project Manager 30 June 2024	**Low**	**Superseded** Relevant parties are identified within the PID; however, it does not include a clear, explicit, end-to-end specification approval workflow. Management previously indicated that agreement would be enhanced through the development of a visual process map, however, no evidence of this has been provided. As a result, the audit is unable to confirm that specification approval and user sign-off arrangements are sufficiently defined or consistently applied. Consequently, this element of the recommendation cannot be considered closed and is reported as **superseded**, with the underlying control intent remaining outstanding (see **Key Finding 1**).
3.2	Inspections undertaken by technical staff should be formally documented and communicated to the Senior Supplier, User, and commissioning leads as part of the quality acceptance process.	Project Manager 30 June 2024	**Low**	**Closed** Vehicle inspections are undertaken and formally documented by the Vehicle Working Group. Inspection outcomes are reported to the Senior Supplier, User, and commissioning leads as part of the quality acceptance process. Sufficient evidence was provided to demonstrate that this recommendation has been implemented as intended and can therefore be considered closed.

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Update and Audit Assessment
Procurement Strategy (Operation)				
4.1	The various aspects of the procurement strategy should include: (a) Enhanced narrative within the business justification case; and (b) Evaluation and approval by appropriate parties to confirm that it remains optimal (as detailed within the business case for approval) ensuring procurement and contractual arrangements deliver best value and align with strategic partnering objectives.	National Fleet Manager and Project Manager At future business case compilation (by December 2024)	**Medium**	**Closed** (a) Review of the approved 2026/27 BJC confirms a substantially improved narrative, clearly setting out the procurement rationale, strategic alignment, constraints, and delivery mechanisms. (b) Governance approvals and oversight arrangements are clearly evidenced. The Procurement Strategy adopts a purchase only model, with leasing explicitly ruled out due to bespoke nature of ambulance builds. The rationale for this approach is clearly articulated within both the PID and BJC. On this basis, the audit is able to support closure of this recommendation.
4.2	Duties for dialogue and negotiation relating to specification costs and pricing should be clearly delineated between procurement and project officers within the Project Initiation Document.	Project Manager At future PID development as part of project delivery (anticipated June 2024)	**Medium**	**Superseded** While the PID identifies procurement and project roles and recognises NWSSP Procurement Services as the procurement lead, it does not explicitly define responsibilities for commercial dialogue, cost negotiation, or supplier pricing discussions. The separation of roles between procurement officers (commercial responsibility) and project officers (technical responsibility) is implied but not formally documented. Therefore, we are unable to support the closure of this element of the recommendation. The control intent remains relevant and has been re-reported through **Key Finding 1**.
Contracts (Operation)				
5.1	Contracts should be discretely authorised in accordance with Standing Orders and Standing Financial Instructions.	Executive Director of Finance & Corporate Services and Trust Board Secretary	**High**	**Closed** At the 2024/25 follow up, management confirmed that '*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*

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Update and Audit Assessment
		31 March 2024		*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.'* As part of this review, Purchase Orders (POs) relating to vehicle conversions and chassis purchases awarded via the CCS framework were examined. For all samples reviewed, approval by the Trust Board and Programme Board was appropriately evidenced and confirmed to be in line with delegated limits. On this basis, audit is able to support closure of this recommendation.
5.2	Pre-tender estimates and variance analysis 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** For the procurement exercises undertaken during 2025/26, review of the procurement outcome reports confirmed the inclusion of pre-tender estimates at the evaluation stage, noting any resulting cost pressures associated with the tender presented for approval.
Monitoring (Operation)				
6.1	Business Justification Cases should present cumulative investment to date (planned and approved) against plans of the Strategic Outline Programme, including variance analysis and commentary (for both vehicle numbers and financial values).	National Fleet Manager At future business case compilation	**Medium**	**Superseded** The 2026/27 BJC demonstrates strong alignment with the VPS and clearly articulates the strategic and operational justification for the planned investment. However, it does not include the expected comparison of investment to date against the SOP, nor does it provide variance analysis or commentary for vehicle numbers or financial values. Therefore, we are unable to support the closure of this recommendation at this time. The underlying control requirement remains outstanding and is reported through **Key Finding 2**.

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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Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Service 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.

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Public Sector Internal Audit Standards

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

Data Management Practices/Devolved Data

Final Internal Audit Report

2025/26



Reasonable Assurance

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Fieldwork	September-October 2025
Executive Sign Off	May 2026
Audit Committee	June 2026
Executive Lead	Jonny Sammut, Director of Digital
Head of Internal Audit	Osian Lloyd

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Executive Summary

Purpose

To review the use of data and provision of information in areas outside the Digital function, and to assess the processes in place to ensure compliance with relevant standards and best practice.

Overview

We have concluded reasonable assurance in this area. There are a number of departments which provide information products to stakeholders independently of Digital. Whilst this demonstrates a positive intent to use data effectively and staff involved are generally aware of data governance requirements, the lack of a formal coordination structure has lead to duplication, inconsistencies, and reporting which does not always meet best practice standards.

The matters requiring management attention include:

- The Trust does not have comprehensive, organisation wide guidance on the appropriate use and presentation of data, and there is no consistent training framework to support staff in applying these standards.
- The processes for developing, verifying, and presenting reports vary considerably, and are often undocumented. This has led to a fragmented and decentralised reporting landscape. In the absence of a central coordination structure, reports have been shared externally without independent review.
- Information produced outside Digital sometimes falls short of established standards and does not always comply with best practice such, as the Office for National Statistics (ONS) guidance.
- Internal validation, quality assurance and version control processes remain inconsistent across departments. This has led to unverified or incomplete data being shared with senior stakeholders.
- Assurance over data accuracy and completeness cannot always be maintained, particularly where data sources outside Digital are used or where reports and extracts are altered post-production. The current decentralised approach also complicates efforts to maintain a single, authoritative "source of truth."

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

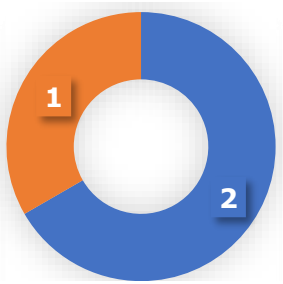
Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	The Trust has guidance in place for all staff on the management and appropriate use of data.	1	**Reasonable**
2	Information products produced outside of Digital comply with relevant standards and best practice, ensure security of information and appropriately meet user needs.	2	**Reasonable**
3	Information products produced outside of Digital promote the effective use of data and maintain appropriate data quality throughout their lifecycle.	3	**Limited**

Management Actions

1	2
High Priority	Medium Priority

Theme



Risk Types

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: The Trust has guidance in place for all staff on the management and appropriate use of data.	**Reasonable**

The Welsh Ambulance Services University NHS Trust (WAST) has established a number of guidance documents and frameworks governing the management and use of data, primarily within its Digital functions. These include the Information Governance (IG) Policy, which provides clear guidance on how data should be validated, managed, and presented across the organisation. Key documents such as the Official Statistics Step-by-Step Guide, the Ambulance Quality Indicators Technical Guidance Document, and the Monthly Official Statistics Pre-Release Guidance provide direction on data quality, consistency, and reporting processes.

While the existing documentation provides strong technical and procedural direction for data professionals, their applicability across the wider Trust is limited. Apart from the IG Policy, most guidance is primarily tailored to specialist teams, with minimal evidence of organisation-wide standards or training to ensure consistent understanding and compliance among all staff. Departments outside the Digital directorate produce their own reports and analyses, and employ data analysts who confirmed they do not follow Insight and Data Services (IDS) specific guidance. Instead, they often rely on informal or peer-led processes for managing and validating data. This issue was highlighted in a paper produced by the Director of Digital, which stressed the need to move to a model based on formally validated data points delivered into the enterprise data warehouse, rather than relying on derived or ad hoc logic.

We noted a positive culture of data responsibility among staff interviewed outside of Digital, with general awareness of data protection obligations under General Data Protection Regulation (GDPR) and the Data Protection Act. Staff know when to seek specialist advice, particularly from the Data Protection Officer, which helps mitigate compliance risks. However, there remains an absence of a comprehensive, Trust-wide data governance framework that defines clear standards for all employees in relation to data handling, presentation, and storage (See **Key Finding 1**).

Training on data management is largely informal and varies by department, with no mandated or structured programme in place. The Digital Team plans to strengthen oversight through initiatives such as a proposed central data verification process and the introduction of a "verification stamp" to assure data quality before release. However, this work is still in progress, and no completion date has been provided. We also note the intent within the paper to enable professional oversight by Digital over the use and presentation of data across the organisation, along with increased training and up-skilling of staff (See **Key Finding 1**).

Finally, while there is no clear record of all information products produced across the Trust, the Information Asset Register (IAR) provides a record of information assets, including reporting and dashboards, which enables a level of visibility to be maintained.

Key Findings		Risk & Impact	Agreed Management Action
1	**Lack of Consistent Guidance and Staff Training on Data Use** The Trust does not have comprehensive, organisation wide guidance on the appropriate use and presentation of data, and there is no consistent training framework to support staff in applying these standards.	The absence of organisation-wide guidance and a consistent training framework may lead to inconsistent data practices, non-compliance with standards, and inaccurate reporting, increasing the risk of poor decision-making and reputational harm.	**Agreed Action:** • Develop organisation-wide data standards (i.e. the rules) for key variables and metrics to support consistent use and presentation, aligned with best practice. • Document these data standards in a central and accessible data dictionary (i.e. glossary) for use across the organisation. • Introduce training checklist for staff involved in data handling and reporting to evidence compliance (e.g. against IG and Data Quality requirements). **Expected Evidence of Implementation:** • First version of data dictionary and guidance made available on WAST intranet. • Checklist of required training and links to available materials made available on WAST intranet, and a locally held record demonstrating completion for staff who regularly engage in analytical activities to be shared to IGSG for oversight. • Evidence of communication and accessibility of dictionary guidance and training checklist via formal Digital Directorate Notice.
		Medium Priority	**Officer:** Assistant Director of Digital Services: Data & Analytics **Target Implementation Date:** 1) October 2026 - Initial Data Dictionary 2) October 2026 - Training checklist developed and initial record of compliance to IGSG 3) October 2026 - Digital Notices on Siren
	Theme: Policies & Procedures	Control Operation	

Objective 2: Information products produced outside of Digital comply with relevant standards and best practice, ensure security of information and appropriately meet user needs**.**	**Reasonable**

A wide range of information products, including dashboards, forecasts, and reports, are produced outside the Digital Team, particularly within the Operational Delivery Unit (ODU), Commissioning & Strategy, and Clinical Directorates. Because this information is developed and produced within the departments, they generally reflect a clear understanding of operational needs and objectives, making them valuable and demonstrating a strong commitment to supporting service delivery.

However, at present, there is no formal, Trust-wide framework governing report design, organisational style, presentation, compliance with standard and regulations or quality assurance. Staff tend to reuse existing templates or rely on local preferences, which supports internal departmental consistency but contributes to variation across the organisation.

Our testing showed that development, verification, and presentation processes vary considerably and are often undocumented. This has led to a fragmented and decentralised reporting landscape, described by some staff as a "cottage industry" approach to analytics. Many departments create their own dashboards and Excel-based reports independently of the Digital Directorate, with limited coordination or oversight.

In the absence of a central coordination structure, and because Digital does not routinely verify outputs produced outside its control, reports have been shared externally (including with Welsh Government) without independent review (See **Key Finding 2**). When data from other directorates is incorporated, its validity is often assumed rather than confirmed. While some teams provide clear references and source details, others do not consistently include explanatory narratives or attribution. As such, our testing showed that information produced outside Digital sometimes falls short of established standards and does not always comply with best practice such as ONS guidance (See **Key Finding 2**).

Security controls are robust where data is sourced from the Data Warehouse or Power BI environments managed by Digital. However, data stored or processed outside these systems, such as spreadsheets developed by operational teams, sits outside Digital's governance, creating potential risks to information security and data integrity. (See **Key Finding 2**)

Key Findings		Risk & Impact	Agreed Management Action
2	**Fragmented Reporting Landscape and Non-Compliance with Standards** The development, verification, quality assurance and presentation processes vary considerably and are often undocumented. This has led to a fragmented and decentralised reporting landscape. Our testing showed that information produced outside Digital sometimes falls short of established standards and does not always comply with best practice such as ONS guidance.	The absence of standardised, documented processes and central oversight increases the likelihood of inaccurate or inconsistent reporting, unverified data being shared externally, and non-compliance with governance and best practice standards—potentially leading to poor decisions, reputational harm, and regulatory challenges.	**Agreed Action:** • [Management actions as per Key Finding 1 will also help address this risk of non-compliance in Finding 2] • Agree list of **externally** shared reports which require central oversight and review before publication – i.e. the list of reports which will require management and QA by the Digital Directorate. • Provide design principles to ensure consistency and quality in reports and dashboards.
			Expected Evidence of Implementation: • Documented list of regularly shared reports, with identified information asset owners logged on the organisation-wide Information Asset Register or Data Sharing Register (as appropriate). Evidence should be given to IGSG via the monthly Highlight Report, demonstrating that all **externally** shared reports have oversight by a Digital Directorate team / staff member. • Published template document (including brand palette) for self-development of dashboards and evidence of accessibility for staff.
		Medium Priority	**Officer:** Head of Information **Target Implementation Date:** 1) August 2026 - List of external reports with owners logged on IAR / Data Sharing Register 2) July 2026 – PowerBI Design Template
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 3: Information products produced outside of Digital promote the effective use of data and maintain appropriate data quality throughout their lifecycle.	**Limited**

There is clear evidence of strong analytical capability and initiative across the Trust, with several departments developing bespoke reporting tools to meet operational needs. Examples include advanced Excel and Power BI solutions produced by the Operational Delivery Unit and senior paramedics. These demonstrate a commitment to data-driven decision-making and innovation within local teams.

However, this activity often occurs without formal coordination or oversight from Digital, resulting in inconsistent data standards and potential duplication of effort. While most teams draw their data from the central Data Warehouse, some information products rely on manual datasets or local sources, increasing the risk of conflicting figures and undermining confidence in reported outcomes. While some departmental practices have been externally reviewed, internal validation, quality assurance and version control remain inconsistent. This has led to unverified or incomplete data being shared with senior stakeholders, including the Welsh Government. In some cases, two reports present different figures for what appears to be the same measure, without explanation of the variance (see **Key finding 3**).

Digital provides the technical infrastructure and data warehouse for data reporting but has limited visibility of outputs developed elsewhere. Consequently, assurance over data accuracy and completeness cannot always be maintained, particularly where data sources outside of Digital are used or where reports and extracts are altered post-production. The current decentralised approach also complicates efforts to maintain a single, authoritative "source of truth." (see **Key finding 3**).

Positive steps are being taken to improve governance, such as exploring controlled access through semantic data layers and renewed discussions on the need for greater central oversight and strengthening coordination. We also note an aspiration within Digital to develop a data verification "stamp" to demonstrate compliance with data governance and quality standards.

Key Findings		Risk & Impact	Agreed Management Action
3	**Lack of Central Oversight for Data Reporting** Digital provides the technical infrastructure and data warehouse for data reporting but has limited visibility of outputs developed by other areas. Consequently, assurance over data accuracy and completeness cannot always be maintained, particularly where data sources outside of Digital are used or where reports and extracts are altered post-production. The current decentralised approach also complicates efforts to maintain a single, authoritative "source of truth." As there is no central coordination structure, reports have been shared externally without independent review and with unverified or incomplete data being shared with high-level stakeholders.	Decentralised reporting and lack of central oversight increase the risk of inaccurate or incomplete data being shared internally and externally. This can lead to misinformed decisions, reputational damage, and weakened data governance due to the absence of a single authoritative source of truth.	**Agreed Action:** • Following a discussion with ELT in April 2026, it was agreed that it would not possible for Digital to take on assurance of all reporting from WAST whilst analytical practices remain decentralised. It was agreed for an interim period, a Community of Practice (COP) for data and analytics professionals would be established internally to help build resilience, best practice, and professionalisation. This COP will aim to bring together the professionals under some central governance, with a clear operating model, but maintain decentralised ownership of reporting. As the COP itself may take time to embed, the action agreed here is for the COP plan to be developed and presented back to leadership. • Additionally, IDS will develop a certification "stamp" to add to reports and publication to demonstrate level of assurance on the data accuracy and source, and help reduce risk of misinformation. **Expected Evidence of Implementation:** • Presentation of the COP plan to appropriate leadership forum (e.g. Digital Leadership, IGSG or ELT) • Evidence of an approved IDS stamp being utilised on a key report or dashboard
		High Priority	**Officer:** Assistant Director of Digital Services: Data & Analytics **Target Implementation Date:** 1) August 2026 – COP Plan 2) August 2026 - IDS certified stamp
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Fire Safety [Subject]

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust



Reasonable Assurance

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Fieldwork	July 2024 – December 2025
Executive Sign Off	June 2026
Audit Committee	June 2026
Executive Lead	Chris Turley, Director of Finance
Audit Team	Huw Richards, Head of Internal Audit
	David Butler, Audit Manager

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Executive Summary

Purpose

The Regulatory Reform [Fire Safety] Order 2005 (the Fire Safety Order) requires key safety compliances such as risk assessments. It also requires that procedures are operated to support compliance.

This audit undertook an assessment of the controls and practices in place within the Welsh Ambulance Services University NHS Trust (The Trust) to ensure that the key fire safety regulatory requirements were adequately addressed, controls were embedded within the organisation, and appropriate operational application of the defined controls was evidenced. It also sought to assess whether the key issues identified at the prior report had been addressed.

Overview

The previous audit undertaken in 2021 provided "**limited**" assurance. The key issues impacting the opinion at that time included the effective reporting to the Board, effective monitoring of risks, and the need for effective management of dangerous substances. Positive action has been demonstrated in addressing the issues previously raised, together with further implementation of appropriate fire safety governance arrangements within the Trust.

Significant improvements were evidenced since the prior audit, notably the comprehensive coverage of Fire Risk Assessments and substantial action in relation to the same e.g. trained Fire Wardens had increased from 158 to 347 in the preceding 18 months, and annual fire drill compliance had increased from less than 50% of premises to circa 80%. Fire maintenance systems were also subject to detailed and enhanced monitoring. Such improvements have been driven and enacted by the central Estates staff (Fire Safety Officer etc). A partial follow up of the recommendations raised at the 2021 audit (of the two high priority and a sample of medium priority items) determined substantial assurance. The current audit sought to fully review the 2021 agreed recommendations and has determined "reasonable" assurance of current implementation (see full details at **Objective 1** below).

The audit has determined "**reasonable**" overall assurance, with positive assessments determined in relation to four of the five areas considered as a part of the current review. Whilst noting the positive actions taken by management to improve the fire safety governance, procedural, monitoring and reporting arrangements operating within the Trust, weaknesses were identified in the local application of defined requirements at the five premises visited across Wales (Vantage House, Matrix One, Beacon House, Merthyr ambulance station, and Merthyr workshops). These provided a mix of landlord owned premises, ambulance stations, and key support premises (noting the potential for impact to ambulance services from fire at key support buildings).

Key matters raised for management attention included the need to ensure:

- drawings to include all in-situ fire safety controls (to appropriately inform risk assessments);
- additional monitoring (to include Fire Warden coverage and logbooks);
- site specific Fire Warden training
- approval of an in-date Fire Safety Policy (with enhanced procedural and governance content);
- enhanced reporting (to include the status of key actions for higher risk premises and fire drill monitoring updates); and
- compliance with display of evacuation instructions at exits at all sites;

Recognising the need for improved training of local leads, the above may also indicate a wider requirement for improved communication to raise the profile of fire safety issues for all staff.

Positive action has been demonstrated by Trust officers in progressing a number of the above issues subsequent to the completion of the audit fieldwork i.e.

- work has commenced to update fire safety controls at drawings and incorporation into associated evacuation plans;
- a refresh of training needs assessments was underway (as advised by the Fire Safety advisers);
- a draft update of the Fire Safety Policy was being compiled to include controls in respect of audit findings; and
- fire evacuation notices had been revised to ensure compliance.

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	Validation of Management Action - That previously agreed actions had been appropriately actioned by management.		**Reasonable**
2	Governance arrangements - including effective structures, terms of reference, roles and responsibilities, collaboration, resource and expertise.		**Reasonable**
3	Appropriateness of procedures - including effective controls.	1, 2	**Reasonable**
4	Central monitoring & reporting – including drawings and risk assessments, training, incidents, inspections, investment, actions, and assurance provided to relevant forums and the Board (or delegated sub-committee).	3, 4, 5	**Reasonable**
5	Local/Operational arrangements - including: • local management and training; and • implementation of controls including signage, equipment, and guidance; and • records management	6, 7, 8, 9	**Limited**

Management Actions

0 High Priority

9 Medium Priority

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

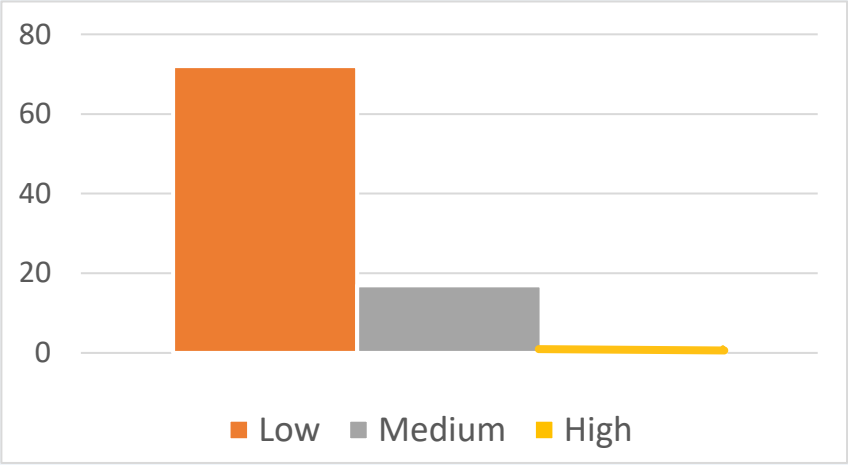
At a Glance

Performance

As reported at the annual Fire Safety Compliance Report (January 2025) all Trust occupied buildings (117 in total) had a current Fire Risk Assessment).

Fire Risk Assessments were categorised risk as follows:

Property Fire Risk Assessment Categorisation



Only one High risk. Circa 80% of Premises assessed as Low Risk

Extract from the January 2026 Fire Safety Report



*19 sites had not completed a fire drill plus a further 6 landlord led sites (circa 40% of Trust owned sites - see **finding 9**)*

Issues identified at each Risk Assessment were categorised as:

Red (urgent), Amber (medium priority), and Green (lower priority)

All of the High Risk and Medium Actions had been addressed at the sole High-Risk property (Aberystwyth).

Management confirmed that in total:

- Red Risk - 192 Actions and 191 addressed (99.5%)
- Amber Risk - 616 Actions and 486 addressed (79%)

i.e. 84% of High & Amber risks have been addressed

Findings & Agreed Action Plan

Objective 1: Validation of management action — **Reasonable**

Overview / Summary of Observations

The prior audit was published in August 2021 providing "**limited**" assurance. The follow-up position may be summarised as:

Recommendations	Priority Level	Implemented	Outstanding	Comments
The Trust should ensure that the reporting of Fire Safety issues is communicated through a formal assurance reporting framework to Board level.	High	1	-	Actioned, as narrated at the **Governance** section.
A DSEAR (Dangerous Substances and Explosive Atmospheres Regulations 2002) report should be commissioned to review the appropriateness of the dangerous substances management arrangements at the Lampeter Ambulance Station (and any other similar premises) and action taken to address any issues highlighted.	High	1	-	A DSEAR report was provided for the Lampeter station. Issues have been raised within this audit regarding DSEAR assessments (as arising from risk assessments). For context, it was noted many medical gas storage units were external to ambulance stations and within secure cupboards. These risks have been assessed within Risk Assessments, and none rated high at the present time.
The Fire Safety Policy will be reviewed (and updated as necessary) in line with the Trust's own requirements on updating Policies – for approval by an appropriate forum.	Medium	-	1	Following the prior audit the Fire Safety Policy was revised and approved on 17th March 2022 in accordance with the recommendation. However, at the time of audit, its renewal was again overdue. Management stated that this was due to the need for a more fundamental review ahead of renewal (the prior author having retired in this interim period impacting this timing). See **Policies and Procedures** At the time of concluding the audit, management advised that procedures have now been re-drafted but await the publication of this audit to finalise. However, a quantum of matters have been identified at this audit requiring further management attention.

The Trust should ensure that the Fire Safety Group Meetings continue to be held on a quarterly basis.	Medium	1	-	Actioned - a Fire Safety Group now meets quarterly.
The Fire Safety Group should receive standardised and consistent reporting on fire.	Medium	1	-	Standardised and consistent reporting was found to be provided to the Fire Safety Group.
The Trust should produce an annual fire safety report in keeping with the requirements of the Trust's Fire Safety Policy.	Medium	1	-	Actioned, as narrated at the **Central Monitoring and Reporting** section.
Risk assessments should be updated within stipulated review periods.	Medium	1	-	Actioned, as per the **At a Glance** section
The Fire Safety Group should have its own fire risk register to ensure that all fire risks are captured.	Medium	1	-	Risk rated recommendations are monitored via a tracker with key thematic risks reported via presentation to the Fire Safety Group. Site specific risks are also fed back via each sites risk assessment.
In keeping with the requirements of the Fire Safety Policy, false alarms will be reported immediately using the Trust incident reporting procedure.	Medium	1	-	Fire safety incidents were recorded at Datix and regularly extracted and reported to the Fire Safey Group.
Fire Wardens will be identified and trained for the 13 Trust premises identified.	Medium	-	1	The Trust confirmed that Fire Wardens remained to be trained at 6 (of 117) premises (48 Trust owned). The current audit also found: *Local Fire Incident Co-ordinators (LFIC) training* LFICs were stated at the Fire Safety Policy as being staff who will have the necessary training to manage incidents. However, this training was not further specified or monitored. *Fire Warden training* Fire Warden training was generic rather than site specific. While training had been provided to operate Fire Safety Panels at some sites, the generic training did not include site related instruction e.g. for emergency light flick tests, rotational alarm testing, completion of the Fire Logbook, ensuring warden cover, or responsibilities as a Fire lead to raise and resolve issues, etc. Similarly, while Fire Warden training was monitored, there was no confirmed acceptance of duties and confirmation of

				familiarity / training with local controls for the Local Fire Incident Co-ordinators. Additionally noting operational issues raised at **site observations,** site specific duties and familiarisation should therefore be included within training. Specialist Fire Warden training was also available at the Shared Services Partnership Specialist Estates Services (NWSSP:SES) web site, which should also be reviewed for applicability. For context, it is noted that the requirement for Fire Safety Wardens and LFICs is as stipulated within the Fire Safety Policy and commissioned Risk Assessments and does not arise directly from the Regulatory Reform [Fire Safety] Order 2005.
Fire safety training in the Trust should be prioritised for all staff.	Medium	1	-	Trained Fire Wardens have increased from 158 to 347 from March 2024 to December 2025, with 82% ESR compliance for general staff fire safety training (noted at the annual report as a significant improvement on prior years). Monitoring and reporting of training was a focus of both the Fire Safety Group and Annual Compliance Report. While the current audit has identified additional issues relating to training of Local Fire Incident Co-ordinators, and the content of training (as assessed above), it also confirmed that Fire Wardens had been trained for all but 6 premises. Coupled with reporting and monitoring evidenced, notwithstanding new issues raised, it was concluded that there had been a prioritisation of fire safety training.
Fire Alarm Tests Either: • an appropriate forum should approve the reduced level of testing on a monthly basis; or • the weekly tests should be reinstated.	Medium	-	1	See **findings 4** & **14** weekly alarm tests from rotated call points remains an issue, as highlighted at *some* Risk Assessments. As noted at the **At a Glance** section – management are prioritising and addressing all recommendations raised at Risk Assessments in a timely manner.
Total		**9**	**3**	

Both the High Priority items had been addressed, and there was partial / on-going actions in relation to the three outstanding. Accordingly, **reasonable** assurance has been determined in relation to delivery of previously agreed actions. However, some 5 years after the prior report full implementation remained to be achieved.

Objective 2: Governance Arrangements	**Reasonable**

Overview / Summary of Observations

The Regulatory Reform [Fire Safety] Order 2005 imposes a duty to manage on the Responsible Person, being the person(s) having control over premises.

The Fire Safety Policy assigns Board level leadership to the Director of Finance. The Fire Safety Manager was designated as the Assistant Director Capital & Estates, with both the Head of Capital & Estates and the Estates Manager acting as Deputy Fire Safety Managers (for the operational application of the Policy). These roles were actively supported by the provision of relevant training.

A Fire Safety Group met quarterly led by the Fire Safety Manager with a wide range of attendees including the Deputy Fire Safety Managers, Estates staff, locality, and service leads. This group was informed by reporting of fire safety issues and additionally summarised within an annual report. However, monitoring systems were manually maintained requiring considerable vigilance and input. Accordingly, there may be an opportunity for improving the effectiveness of the use of existing resources in the operation of the existing monitoring systems, and facilitation of more dynamic reporting (see **Overview**).

The Terms of Reference (ToR) for the Fire Safety Group specified the formal assurance reporting line via the Quality, Patient Experience and Safety Committee through to the Board. The audit evidenced reporting and approvals to both the National Health & Safety Committee, and Finance and Performance Committee. However, both scrutiny and approval responsibilities and oversight and escalation arrangements were not appropriately defined within the procedures (see **Procedures** section finding 2).

While recognising the above matters, noting active monitoring and oversight by qualified officers via a regularly convened Fire Safety Group, **reasonable** assurance has been determined in relation to the existing governance arrangements.

Objective 3: Appropriate Policies and Procedures	**Reasonable**

Overview / Summary of Observations

The Regulatory Reform (Fire Safety) Order 2005 imposes a general duty on the employer to take such fire precautions as may be reasonably required to ensure that premises are safe for the occupants and those in the immediate vicinity via the application of fire safety procedures.

A Fire Safety Policy was in place containing a wide range of fire safety controls and was available at the Trust's Intranet site, however this had expired some months prior to the audit (see also **Objective 1**). While the reporting arrangements of the Fire Safety Group were detailed at its Terms of Reference, the Policy could also detail the scrutiny and approval roles of overseeing committees.

Management have advised that recognising a quantum of matters requiring amendment, it was deemed beneficial for a more fundamental review of the Policy ahead of re-publication

At the time of concluding the audit fieldwork, management advised that the Policy document had been re-drafted but were awaiting the publication of this audit report to also consider any additional points raised. Noting the same and conditional on the early application of the updated Policy, **reasonable** assurance has been determined.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Fire Safety Policy** **a) *Currency*** The Fire Safety Policy containing fire safety procedures was last approved on 17th March 2022 by the Fire Safety Group, Health & Safety Committee, and Finance and Performance Committee. Renewal was due within three years, and therefore the current policy had expired at the time of audit. **b) *Content*** It was evident that there were a range of matters identified within Risk Assessments not included within the Policy e.g. ○ weekly alarm tests from rotated call points; ○ monthly flick tests of emergency lighting; ○ electrical system inspection requirements & frequency. The annual Fire Safety Compliance Report also reported several key matters not contained within the Policy e.g.	Policy deficiencies impact operational controls.	The review and revision of the fire policy is currently underway and will incorporate the feedback and recommendations identified during the fire audit, prior to submission to the Policy Group for formal review.

	○ 6 monthly maintenance checks for detection and alarm systems (as per BS 5839-1:2025); and ○ EICR (Electrical Installation Condition Report) compliance including monthly flick tests. While planned maintenance frequencies were monitored, neither the Policy nor Compliance Report detailed the required frequency of fire drills and associated performance (which awaited risk assessment by the fire consultant), including associated requirements for lower risk premises. Similarly, the directions for DSEAR risk assessments were not specified (with assessments and follow-up actions not available for two of the three owned premises inspected). While recognising that DSEAR issues would be raised by Risk Assessments, specification of minimum requirements for the Annual Compliance Report could also usefully form part of the Fire Safety Procedures. **c) Content - IT System Safeguards** As of 2022 the Fire Safety Policy stated that: "*CT equipment rooms are considered critical in supporting Trust operations. ICT equipment in server rooms together with UPS's and battery storage rooms will be provided with Fire Alarm, Automatic Fire Detection and where appropriate to the risk, Fire Suppression systems. Consideration will be given to linking outputs to a building management system*". Noting the elapsed time since this observation, this matter should therefore now be implemented or rejected via a formally approved proposal as part of renewal of the Fire Safety Policy. There was therefore a need to review the Fire Safety Policy against required criteria both at Fire Risk Assessments, and matters raised within this audit (e.g. soft furniture fire safety labels).		**Expected Evidence of Implementation:** Approval and issue of the revised Fire Safety Policy following review by the Policy Group.
		Medium Priority	**Officer:** Assistant Director of Capital & Estates **Date: November 2026**
	Theme: Policies & Procedures	Control Design	

2	**Committee reporting and oversight** While the Fire Safety Policy identified the general responsibilities of the Trust Board, it did not specify delegated committee oversight e.g. scrutiny and approval responsibilities of the Health & Safety Committee, or the Finance and Performance Committee both of whom approved the current Fire Safety Policies. Management have commented that: • A member of the Senior Estates Team attends monthly/quarterly operational team meetings (e.g. South East Formal Business Meetings, Local Integrated Partnership Forum - all regions, Quarterly Fire Safety Group providing fire safety updates, and advice and discussion e.g. of any incidents). • Fire compliance information is now monitored and updated monthly and captured in an estate's presentation for cascading to the operational team meetings. This will allow enhanced reporting of high risks taken directly from the Fire Risk Assessments to be shared with senior management, the fire safety group and at numerous operational briefings.	Responsibilities may be unclear impacting effective scrutiny and oversight.	**Agreed Management Action:** Monitoring by relevant committees and associated reporting and including approval of the Fire Safety Policy will be clarified at the Fire Safety Group (e.g. to monthly estates meetings, local integrated partnership forums or operational management meetings). **Expected Evidence of Implementation:** We will reflect intended fire safety governance arrangements including monitoring to relevant committees within the Fire Safety Policy.
		Medium Priority	**Officer:** Assistant Director of Capital & Estates **Date:** August 2026
	Theme: Governance	Control Design	

Objective 4: Central Monitoring and Reporting	**Reasonable**

Overview / Summary of Observations

The Fire Safety Policy states that the Trust Board expects those tasked with managing fire safety to develop and implement monitoring and reporting mechanisms appropriate to the management of fire safety. It specifically requires the production of an annual fire safety report and submission to the Trust Board. Associated reporting, notably via the Fire Safety Group is also required to support operational monitoring. Such reporting was in place.

An annual Fire Safety Compliance Report was provided to the Finance & Performance Committee in January 2025. This included commentary on technical compliance, risk assessments completed and associated actions. This was supplemented by reporting on operational matters to the quarterly Fire Safety Group (such as incidents, and completion of risk assessments, fire drills, and training). The Annual Report detailed the proportions of high / medium risk premises, together with top risks remaining (see **At a Glance** section), however, it did not report whether actions had addressed key issues at the highest risk premises.

Monitoring systems also included a Planned Preventative Maintenance system with a fire specific spreadsheet, and a Risk Action Tracker, all with alert provisions for any overdue actions. The audit determined that monitoring systems could usefully be supplemented by checklists of landlord and tenant responsibilities together with systems to ensure full coverage by Local Incident Co-ordinators (see **local/Operational arrangements**).

Risk Assessments were in place for all premises (refreshed cyclically on a 5 yearly basis, or upon significant change) as required by the Fire Safety Policy. However, there was a need for drawings to include all fire safety controls to inform these assessments. There was also a need for a system to trigger fresh reviews following building alterations. Management advised that new site drawings were in preparation and recognised the need for a system to trigger updates.

While recognising the above issues, noting a range of monitoring including reporting at both committee and operational levels, **reasonable** assurance has been determined in relation to central monitoring and reporting.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Drawings** Drawing information informs both risk assessment and Fire Service response. Indeed, the Risk Assessments test for both zone diagrams, and drawings highlighting fire safety and risk related items. Accordingly, while not mandatory, best practice and compliance with (the mandated) Risk Assessments would be for drawings to include such items as: ○ *fire detection systems;* ○ *emergency lighting;* ○ *hydrants and dry or wet risers;*	Fire safety risks are missed due to insufficient drawings. Fire service response is impacted by insufficient drawing information.	(a) Site drawings will include fire safety measures (b) The updated drawings will be displayed adjacent to the fire panel within premises. (c) The updated drawings will be displayed in the entrance to each premises.

	○ *suppression systems including sprinklers and dampers; and* ○ *any high-risk areas / hazards.* Drawings included compartmentation, fire doors and escape routes, but not the above items. The drawings were also limited to the building interiors. At the time of the audit, site plans were not available detailing external hydrants or hazards within the site perimeter e.g. a hydrant at Merthyr workshops, and gas cylinder storage adjacent to ambulance parking at Beacon House. Risk Assessments were stated at the Fire Safety Policy to be refreshed five yearly "*in the absence of significant change*". There was therefore a need to trigger drawing and risk reviews following building alterations and / or review the frequency of renewal. Management advised that new site drawings were in preparation to address these matters. Coupled with this need, there was also scope for review of the Policy (noting its pending renewal), in liaison with consultants to ensure appropriate inclusions at drawings. At the time of publication of this report, management had provided evidence that drawings had been updated at 26 premises. These had been prioritised to ensure all larger premises, and those core to operations had been updated. These will displayed adjacent to the fire panel and may also be displayed in the entrance to each premises as per the Fire Risk Assessment guidance. The remainder of Trust premises were in process of being addressed.		**Expected Evidence of Implementation:** (a) Updated site drawings including fire safety measures (b) The updated drawings (including fire safety measures) will be displayed adjacent to the fire panel within premises. (c) The updated drawings (including fire safety measures) will be displayed in the entrance to each premises.
	Theme: Risk Management	**Medium Priority** Control Operation	**Officer:** Assistant Director of Capital & Estates **Date:** November 2026
4	**Monitoring landlord and tenant responsibilities** For leased premises, any deficiencies in performance of landlord responsibilities were identified within Fire Risk Assessments. However, these were generally only refreshed every five years. It was not stated within the Risk Assessments as to whether they were based on typical responsibilities or assessment of the specific lease agreements. Operational monitoring arrangements do not currently detail landlord and tenant responsibilities (in accordance with the leases).	Landlord and tenant responsibilities are may not be fulfilled impacting fire risks and staff safety.	**Agreed Management Action:** Our appointed Fire Consultants are advising on this issue and will assist us in ensuring that landlord and tenant responsibilities are clearly delineated for properties not owned by the Trust. **Expected Evidence of Implementation:** Delineation of landlord and tenant responsibilities for properties not owned by the Trust at Fire Safety Group and Annual Fire Safety Report.

	Management advised that this matter was in process of being addressed.	**Medium Priority**	**Officer:** Assistant Director of Capital & Estates **Date:** November 2026
	Theme: Contractual	Control Operation	
5	**Annual reporting** *Priority ratings* Reporting showed proportions of high, medium and low risk premises. It also reported that 2/3rds of recommendations at the Risk Assessments were denoted as actioned. However, it was not possible to determine whether the urgent (red) issues relating to high or medium risk premises had been actioned. *Maintenance* The Policy requires appropriate maintenance of fire safety systems to be evidenced. However, associated performance was not summarised at the annual Fire Safety Compliance Report.	Reporting does not sufficiently inform management of risks to optimise mitigating actions.	**Agreed Management Action:** We will ensure that the Fire Safety Compliance Report includes both maintenance and a grid of prioritised actions at High, Medium and Low risk premises. **Expected Evidence of Implementation:** Publication of the Fire Safety Compliance Report including both maintenance and a grid of prioritised actions at High, Medium and Low risk premises.
		Medium Priority	**Officer:** Assistant Director of Capital & Estates **Date:** February 2027
	Theme: Reporting	Control Operation	

Objective 5: Local/Operational arrangements	**Limited**

Overview / Summary of Observations

The Fire Safety Policy requires Local Fire Incident Co-ordinators (LFICs) to initiate the local fire emergency action plan. Similarly, a requirement is placed on Fire Safety Wardens for local application of the Fire Safety Policy.

Local systems were tested at walk arounds undertaken at five (of 117) sample premises. These were selected to include a mix of office premises with landlords (Vantage House and Matrix One), and ambulance stations with both external and integral ambulance parking (Beacon House – Cwmbran, and Merthyr respectively). The Merthyr fleet workshop was also sampled, being a single point of failure for the Trust ambulance support (as noted at the Fire Safety Policy).

Fire Wardens were in place at each of the five sampled premises. An appropriate range of in-date (tested) extinguishers were in place at these premises with appropriate exit and emergency door signage. With a single exception, all equipment was PAT tested, and fire exits were clear of obstruction. There were also contracts in place assuring maintenance of alarm and suppression systems and associated records. Local issues were found to be appropriately logged and escalated via an on-line reporting system via the Fire Wardens.

Fire drills are not required by the Fire Safety Order. However (externally commissioned) Fire Risk Assessments have stipulated the need for annual drills. The Fire Safety Policy recognises the need for regular drills and also notes the need for these to cover all shifts. Monitoring reports did not include reference to shifts and showed that annual fire drills remained to be undertaken at some premises.

A range of issues were found at audit walk around including several key matters at the 999 call centre, and issues of accessing a fire hydrant at the fleet workshop (both key facilities to Ambulance operations). Prior audits had highlighted matters such as the need to complete logbooks (recording fire drills, and equipment inspections etc). The current audit found recurrence of these issues and also noted the need for Fire Warden training to include building specific tasks such as log-book completion. The issues found at premises visited had not been raised by fire wardens (see **site observations)**. There was also a need to specify / better specify evacuation procedures at the entrance to premises (continuing failure to comply with the requirements of the Fire Safety Policy at 40% of premises visited). As noted previously, there was additionally a need to ensure that sufficient and trained Fire Wardens and Local Incident Co-ordinators were in situ at all premises. Noting the number of sites and control issues, it was evident that communication and devolved control were key issues.

While recognising controls in place, noting the range and quantum of issues identified in a limited sample, **limited** assurance has been determined in relation to the application of procedural/policy requirements at Trust premises.

	Key Findings	Risk & Impact	Agreed Management Action
	Site observations At fleet workshops in Merthyr, prior to the audit the location of the fire hydrant was not immediately apparent, being both obscured and obstructed by parking (though a required plaque was in place at the main premises indicating its location). It was also absent from site drawings and therefore not shared with the Fire Services.	As assessed below	N/A - see sections below

	At Vantage House, fire safety issues were apparent during the audit walk around e.g. non fire rated doors to two electrical cupboards labelled as fire doors (on the main corridor), gaps around cabling and cardboard storage in the cupboards. While maintenance of these doors and cupboards was a landlord responsibility, the deficient fire doors were an apparent risk for staff at the premises. A third electrical cupboard (Trust responsibility) had exposed wiring from a connector (lacking a cover). While the more general responsibility to identify risks rests with the expert Risk Assessments, it is noted that these are only renewed every five years. The observed matters are also relevant to obtaining appropriate landlord assurances (also see **Finding 4 - Monitoring of landlord and tenant responsibilities**). The above issues had not been raised by fire wardens (also see Finding 6 - **Fire Warden / Local Incident co-ordinators**).		
6	**Fire Warden / Local Incident co-ordinators** **Coverage** *Local Fire Incident Co-ordinators (LFIC)* *LFICs* were defined at the Fire Safety Policy as being responsible for overseeing all on-site emergency responses. The LFIC were typically the most senior manager for an area "*who have the necessary operational training to manage incidents*", as listed by the Estates and Operations Departments. However, a system / list of Local Incident Co-ordinators assuring shift cover was not in place to provide clarity as to such expectations. *Fire Wardens* As previously noted, the annual Fire Safety Report noted the need to appropriately train Fire Wardens. Good practice was noted in the increase in Fire Warden training in recent years (from 158 officers in March 2024 to 276 by September 2025). The Fire Safety Policy assigns, Fire Wardens the key operational role for local fire controls. The annual report further states that: *"a suitable number of persons should be trained to ensure that adequate cover is provided in the event of an*	Fire Wardens are not appropriately trained impacting operational fire safety controls.	**Agreed Management Action:** We will therefore look to confirm full shift coverage of trained Fire Wardens for all premises, and Local Incident Co-ordinators at clinical contact centres and larger ambulance stations in accordance with the revised Fire Safety Policy with reporting via the Fire Safety Group. **Expected Evidence of Implementation:** Confirmation of full shift coverage of trained Fire Wardens at all sites and Local Incident Co-ordinators in accordance with the revised Fire Safety Policy via reporting to the Fire Safety Group.

	evacuation for "every operational hour" and available 24 hours a day. A full list of trained site-specific Fire Warden's should be prominently displayed on site". Fire Warden coverage remained to be put in place for 6 (of 48 Trust owned) premises (117 premises in total). Similarly, a theme at the commissioned Risk Assessments was the absence of Fire Warden lists at the entry to premises (though this was in place at three of the five tested premises). (see also **Validation of Management Actions** – Outstanding Action - Training – at **Objective 1**). Management have commented that: • A member of the Senior Estates Team attends monthly/quarterly operational team meetings (e.g. South East Formal Business Meetings, Local Integrated Partnership Forum - all regions), Quarterly Fire Safety Group) which allows us to provide updates in relation to Fire Warden training, advise of sites where more Fire Wardens are required and provide an update on annual fire drills completed/outstanding. It's also an opportunity to discuss any fire incidents that have taken place and any notable actions brought to the team once site-specific fire risk assessments have been completed. • Fire compliance information is now monitored and updated monthly and captured in an estate's presentation for cascading to the operational team meetings. This will allow enhanced reporting of high risks taken directly from the Fire Risk Assessments to be shared with senior management, the fire safety group and at numerous operational briefings.		
	Theme: Training & Development	**Medium Priority** Control Operation	**Officer:** Assistant Director of Capital & Estates **Date:** February 2027
7	**Fire Logbook** The Fire Safety Policy states that records of fire tests, drill and false alarms etc. will be held in the Fire Logbook located at all Trust premises and be reported to the Estates Helpdesk Fire Logbooks were not comprehensive across tested sites, though were supplemented by Estates records. In the case of Matrix One, records of fire exits, and maintenance were sought by the Facilities Manager (Deputy Fire Safety Manager) from the landlord to inform the audit.	Incomplete records and monitoring permit incomplete controls	**Agreed Management Action:** (a) Required inclusions within local logbooks, and local records to be provided held centrally will be clarified within the Fire Safety Policy including those to be held / provided by landlords. (b) Fire Warden and Local Incident Co-ordinator training will include reference to the Fire Safety Policy and the need to implement associated local procedures and local actions arising from Fire Risk Assessments and audit.

	Similarly, rotational testing of alarms was not evidenced in three of the five premises visited and flick testing was not recorded. Other local matters included the need for fire safety labels on soft furnishings (not provided at three of the four tested premises with such furniture) *(in accordance with Furniture and Furnishings [Fire Safety] Regulations 1988/1989, 1993 and 2010).* There was therefore a need to review instructions and training in relation to completion of Fire Logbooks together with central monitoring of the same. As noted, in context, many of the records were variously available e.g. from electronic records or landlords but not facilitated by fully documented local logs. Noting the potential for duplication and omission, management could review the core content required locally and defined accordingly within the Fire Safety Policy.		**Expected Evidence of Implementation:** (a) Required inclusions within local logbooks and local records to be provided held centrally will be clarified within the revised Fire Safety Policy. (b) Inclusion within Fire Warden and Local Incident Co-ordinator training of reference to the Fire Safety Policy and the need to implement associated local procedures and local actions arising from Fire Risk Assessments and audit.
	Theme: Risk Management	**Medium Priority** Control Operation	**Officer:** Assistant Director of Capital & Estates **Date:** August 2026
8	**Evacuation procedures** The Fire Safety Policy states that **"***each building is legally required to have a written evacuation procedure on display in the front entrance of the building near to the entrance or reception".* Risk Assessments had documented that sufficient notices were not in place for two of the five tested premises (Beacon House, and Merthyr Workshops). The Facilities Manager described the evacuation procedures as being universal across the Trust - to simply exit the premises, with the Local Fire Incident Co-ordinator / lead Fire Warden conducting a sweep of the premises to confirm full exit. Accordingly, the need for instruction at entry to premises would be minimal but should include specific reference to assembly points. However, the approach was not defined within the central procedures, and it was unclear as to whether issues raised at the risk assessments had been satisfactorily resolved. There was also some disparity between this approach and certain local implementations where signing-in logs had also been reviewed in test exits.	Unclear evacuation procedures result in sub-optimal exit.	**Agreed Management Action:** (a) Evacuation procedures will be clarified within the Fire Safety Policy including requirements for exit signage e.g. as in accordance with British Standards and detailing local assembly points. (b) We will ensure the placement of appropriate evacuation procedures within buildings. **Expected Evidence of Implementation:** (a) Updated evacuation procedures within the Fire Safety Policy. (b) Placement of appropriate evacuation procedures within all buildings.

	At the time of publication of this report, management had provided evidence that a first tranche of 26 prioritised sites (including those with the largest floor areas) had been surveyed, with plans drawn up for means of escape, fire-fighting equipment and assembly points determined. These will be posted within each building by the end of May 2026. The remaining sites have been commissioned and the surveying process commenced (see also **Finding 3** above).		
	Theme: Risk Management	**Medium Priority** Control Operation	**Officer:** Assistant Director of Capital & Estates **Date:** (a) August 2026 - see finding 1 (b) June 2026
9	**Fire Drills** The Regulatory Reform [Fire Safety] Order 2005, requires that: "*The responsible person must establish and where necessary, give effect to appropriate procedures, including safety drills*." To accord with this, the Fire Safey Assessments (external assessor) recommended that fire drills should be undertaken as a minimum, annually. The Fire Safety Policy also noted the need for multiple drills at each premise for shift coverage. Good practice was evidenced at all five premises tested at this audit with in-date fire drills and monitoring reported at the Fire Safety Group. However, it was reported to the January 2026 Fire Safety Compliance Group that 19 sites (of the 48 Trust owned sites) remained to complete an annual fire drill, with a further 6 to be scheduled at landlord owned sites – circa 40%). Such monitoring related only to one annual drill per premise (not additionally for each shift). It also excluded small / rented office type premises with limited / occasional staffing. Management advised that this was to be reflected in the updated Fire Safety Policy. The 2025 Fire Safety Compliance Report stated that "*annual fire drills have now been added to the 3i Studio CAFM system and an annual planned preventative maintenance (PPM) task will be raised to prompt all site responsible persons that they*	Procedures are not appropriately tested risking safety errors in live evacuation.	**Agreed Management Action:** We will ensure annual Fire Drills for each shift within clinical contact centres and annually at all premises. **Expected Evidence of Implementation:** Reporting of full annual fire drill compliance for each shift within clinical contact centres and annually at all premises.

	need to complete their annual drill". It stated that drills were "*being completed at larger sites but not historically at smaller Ambulance Stations*" e.g. including road site facilities and small office rentals. Management further advised that the audit that the issue largely related a need to recognise a multi-tier requirement (based on risk) within revised procedures.	**Medium Priority**	**Officer:** Assistant Director of Capital & Estates **Date:** August 2026
	Theme: Risk Management	Control Operation	

Appendix A

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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Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Service 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 Welsh Ambulance Service 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.

Public Sector Internal Audit Standards

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

High Risk Record Policy

Final Internal Audit Report

2025/26

Welsh Ambulance Service University NHS Trust



Reasonable Assurance

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Review Reference	WAS-2526-12
Fieldwork	March - May 2025
Executive Sign Off	12 June 2026
Audit Committee	June 2026
Executive Lead	Lee Brooks, Executive Director of Operations
Audit Team	Osian Lloyd, Head of Internal Audit
	Felicity Quance, Deputy Head of Internal Audit

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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

This review assessed the mechanisms in place to record and store information in relation to High Risk Records (HRRs), including how information is acted upon to inform operational responses to requests for assistance and support the safety and security of staff and service users.

Overview

HRRs are designed to alert staff to situations where increased caution is required, enabling informed decision-making and the implementation of appropriate protective measures. These records play a critical role in supporting safe and effective service delivery while reducing the risk of harm.

The High Risk Record Policy is intended to provide a structured framework for the identification, recording and management of risks relating to staff safety, patient care, and service delivery, supporting compliance with statutory, regulatory and information governance requirements.

We have concluded reasonable assurance on this area. Key systems and processes are in place to support the operational use of HRRs, and there is evidence that risk information is effectively captured and made available to inform decision-making at the point of response. In particular:

- HRRs are clearly visible within the CAD system, enabling call handlers to identify risks promptly.
- Alerts are used to inform operational decision-making, supporting staff safety and patient care.
- Proportionate information sharing arrangements are in place with partner organisations.
- Work is underway to strengthen processes, including the development of a digital HRR submission solution.

However, a number of control weaknesses were identified which require management attention:

- The Policy does not define reporting or escalation arrangements, and there is currently no formal reporting of HRRs to a governance forum.
- The HRR process remains largely manual, with a need for digitalisation to improve completeness, consistency, and auditability.
- HRR documentation is not centrally stored, increasing the risk of loss or incomplete audit trails.
- Instances of inappropriate records and inconsistent use of documentation were identified.
- Notification letters to service users are not consistently issued following the creation of a HRR.
- A backlog of HRRs requiring annual review was identified, indicating that records are not consistently maintained or removed in line with policy.

Full details of matters arising, together with management actions and implementation plans, are set out in the Findings & Agreed Action Plan section of this report.

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	There is a policy in place which clearly defines roles, responsibilities, and governance arrangements across the Trust	1	**Reasonable**
2	There are appropriate processes in place for requesting, authorising, recording and maintaining High Risk Records	2,3,4,5,6	**Limited**
3	High Risk Records are used effectively to inform responses and trigger timely protective actions and escalation, with mechanisms to alert staff promptly and training to ensure appropriate identification and response.		**Reasonable**
4	Appropriate access controls, audit trails, and retention/disposal procedures are in place to safeguard confidentiality, and that information sharing with public authorities is lawful, and compliant with data protection standards.	6	**Reasonable**
5	Monitoring mechanisms, including regular audits, are in place to provide assurance that the Trust fulfils its statutory and organisational responsibilities for managing High Risk Records.	7	**Limited**

Management Actions

3 High Priority

4 Medium Priority

Themes



Risk Types

Public Perception & Reputational Risk

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: There is a policy in place which clearly defines roles, responsibilities, and governance arrangements across the Trust.	**Reasonable**

A review of the Trust's SharePoint site confirmed the existence of a High Risk Record Policy (approved by the Finance and Performance Committee July 2020; with a review date of July 2023), which outlines its approach to identifying and managing high-risk information relating to patients or members of the public, with the aim of protecting both staff and service users.

The policy outlines a number of key areas including the definition of high-risk records, categories of high-risk alerts, processes for requesting alerts, maintenance of the high-risk register, and detailed descriptions of six alert types. It also clearly defines roles and responsibilities across all organisational levels, including the Chief Executive, Board Secretary, Executive Directors, Policy Leads, Departmental Leads, Line Managers, and all staff.

However, the policy does not set out arrangements for reporting on high-risk records or for the escalation of issues to an appropriate Committee or governance forum.

During the audit, a revised draft version of the High Risk Record Policy was provided. This draft introduces a number of enhancements when compared to the current policy. These include updated alert categories, notably the addition of a seventh category relating to infectious or communicable diseases; the implementation of a digitised process supported by the High Risk Records App; and strengthened information governance and audit arrangements, including the proposed introduction of an annual audit

Notwithstanding these improvements, the revised draft policy does not address the gap identified in the current policy in relation to reporting or escalation. Specifically, it does not define arrangements for the routine reporting of high-risk records or for escalation to an appropriate committee or governance forum (see **Key Finding 1** and *objective 5*).

Key Findings		Risk & Impact	Agreed Management Action
1	**Gaps in Governance, Reporting and Escalation within the High-Risk Record Policy** The High-Risk Record Policy (both current and draft versions) does not include defined reporting or escalation arrangements to an appropriate committee or governance forum.	High Risk Record issues may not be effectively monitored, escalated, or consistently understood across the Trust, limiting governance oversight.	**Agreed Action:** The High-Risk Record Policy will be updated to include clear governance, reporting and escalation arrangements. This will set out the governance forum responsible for oversight, the frequency and content of routine reporting. The policy will also be supported by a communication plan to raise awareness of the revised arrangements across relevant teams.
			Expected Evidence of Implementation: • Approved updated HRR policy. • Evidence of communication/awareness activity. • Evidence of reporting of High-Risk Records through local business meetings and the Senior Operations Team (SOT) via Triple A reporting.
		Medium Priority	**Officer:** Assistant Director of Operations, Coordination & Integrated Care
	Theme: Policies & Procedures	Control Design	**Target Implementation Date:** December 2026

Objective 2: There are appropriate processes in place for requesting, authorising, recording and maintaining High Risk Records.	**Limited**

The High Risk Record (HRR) process is initiated when a potential high-risk individual or location is identified. There are six defined alert categories: Staff Safety Risk, Children in Special Circumstances, Medical Need, Frequent Callers, Access and Information, and Specialist Sites. A seventh category relating to infectious or communicable diseases has been introduced within the draft policy.

HRRs may be raised by a range of sources, including Trust staff, healthcare professionals, safeguarding teams, patients or caregivers, and external organisations, often following incidents such as violence, safeguarding concerns, or identification of specific clinical or access needs.

The formal process requires completion of a High Risk Record Information Report Form (HRRIRF), capturing key information including patient details, risk description, and review date. Temporary alerts may be applied for up to 14 days pending receipt of documentation; however, we note that this has been extended in practice to 30 days due to delays in submission because of operational pressures. Where information is not received within this timeframe, no record is included on the Computer Aided Dispatch (CAD) system. This control was confirmed through testing, with one of our sample identified as a temporary record that was subsequently removed due to the absence of a completed HRRIRF. Once validated, HRRs are recorded on the CAD system for a standard 12-month period and are subject to periodic review.

The process is largely manual, with forms submitted via email and stored in Outlook folders before being uploaded to CAD. A digital solution (High Risk Records App) is currently in development to improve efficiency and data quality.

To assess compliance, we selected a sample of 40 HRRs from records added, amended and removed during 2025 (20 added, 10 amended, 10 removed). Testing of newly created records identified that:

- Two HRRIRFs could not be located, indicating possible deletion (see **Key Finding 2**).
- One record did not meet HRR criteria and related to a separate operational issue (defibrillator maintenance), resulting in an inappropriate system alert. The record applied a street indicator affecting all calls in the area and remained in place after the issue had been resolved; it was subsequently removed during testing (see **Key Finding 3**).
- Two instances of incomplete documentation were identified, including a missing page. Incomplete forms are not returned for completion; instead, missing information is inferred by the EMS team (see **Key Finding 4**).
- A non-standard HRRIRF template was used in one case.

The policy requires that individuals subject to an HRR are notified via a standard letter, with a template included in the appendices. However, when evidence of notification letters was requested for the sample of 20 newly added records, only one instance was identified from the 16 cases received, indicating that this requirement is not being consistently applied (see **Key Finding 5**).

The policy also requires annual review of all HRRs. At the time of review, 361 records had surpassed their required review date. Although reminders should be issued four weeks in advance, this has not occurred for approximately for 12-16 months due to resourcing pressures. Testing of amended records found appropriate updates; however, only one of ten cases evidenced completion of the required review form (see **Key Finding 6**).

No issues were identified in relation to records removed from the CAD system, with appropriate rationale documented.

Key Findings		Risk & Impact	Agreed Management Action
2	**Inadequate Storage and Retention of HRR Documentation** High Risk Record Information Report Forms are submitted to a shared email inbox and stored within Outlook folders. During testing, two forms could not be located, indicating potential deletion and lack of secure document retention.	HRR documentation may be lost or not retrievable, leading to non-compliance with records management requirements and reduced audit trail.	**Agreed Action:** Implementation of the High-Risk Record App as the standard mechanism for submission and storage of High-Risk Record documentation, replacing reliance on email inboxes and Outlook folders. The new process will provide a centralised and secure repository for supporting documentation, with defined access controls, retention arrangements and improved traceability between submitted information and the corresponding CAD record.
			Expected Evidence of Implementation: • Communication of the High-Risk Record App. • Redacted screen shots of the SharePoint site demonstrating the High-Risk Record App in operation. • Approved updated policy.
		Medium Priority	**Officer:** Judith Bryce, Assistant Director of Operations **Target Implementation Date:** December 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
3	**Weaknesses in Validation of High Risk Records** Testing identified an instance where a High Risk Record was created for an issue that did not meet defined HRR criteria (defibrillator maintenance). The alert applied a broad system flag without appropriate justification or supporting documentation.	Inappropriate records may be created, reducing data accuracy and resulting in misleading or unnecessary alerts.	**Agreed Action:** The implementation of the High-Risk Record App will include mandatory fields, standardised approval steps and validation checks to support consistent review of submissions before a record is added to CAD. Supporting guidance will also be updated to clarify decision-making and authorisation requirements.
			Expected Evidence of Implementation: • Approved policy and supporting guidance defining HRR criteria. • App workflow showing mandatory fields and validation controls.
		Medium Priority	**Officer:** Judith Bryce, Assistant Director of Operations **Target Implementation Date:** December 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

4	**Manual and Inconsistent HRRIRF Submission Process** The current High Risk Record Information Report Form process relies on a manual Word-based template to capture and submit requests. Testing identified instances of incomplete and inconsistent submission, including missing information and use of non-standard forms, highlighting weaknesses in data capture and validation.	Incomplete or inconsistent information capture reduces data quality, auditability, and effective oversight.	**Agreed Action:** The current manual Word-based High Risk Record Information Report Form process will be replaced with a standardised digital submission process through the High-Risk Record App. The revised approach will require use of a single approved template, supported by mandatory fields and consistent workflow stages, to improve completeness, consistency and auditability of information submitted for review.
			Expected Evidence of Implementation: • Digital form/system in use - HRR App. • Evidence of fully completed submissions Screenshots. • A copy of the How To guide.
		Medium Priority	**Officer:** Judith Bryce, Assistant Director of Operations
	Theme: Information, Data Quality & Data Accuracy	Control Design	**Target Implementation Date:** December 2026
5	**Failure to Notify Individuals of High Risk Record Inclusion** The policy requires that individuals are notified when a High Risk Record is applied, with a template included in the appendices. Testing of newly created records found that this is not being consistently applied, with evidence of notification identified in only one of 16 cases.	Failure to notify individuals may result in non-compliance with data protection requirements and reduced transparency.	**Agreed Action:** The revised policy and implementation process will clarify when notification is required, assign responsibility for issuing and recording the notification, and introduce monitoring to provide assurance that this requirement is being consistently applied.
			Expected Evidence of Implementation: • Approved policy and How to Guide. • Screenshots of App "letter sent". • Copy of reports through the governance routes (SOT).
		High Priority	**Officer:** Assistant Director of Operations, Coordination & Integrated Care
	Theme: Quality, Safety & Patient Experience	Control Operation	**Target Implementation Date:** December 2026

6	**Ineffective Review and Maintenance of High Risk Records** The policy requires annual review of all HRRs. A significant number of HRRs (361) had surpassed their required review date. Although reminders should be issued four weeks in advance, this has not occurred for approximately for 12-16 months due to resourcing pressures. Testing of amended records found appropriate updates; however, only one of ten cases evidenced completion of the required review form.	Outdated or inappropriate records may remain active, potentially impacting decision-making and patient safety.	**Agreed Action:** The High-Risk Record App will provide automated notifications to system leads 4 weeks prior to the 12-month timeframe to prompt system leads to complete a review of the high-risk records, with appropriate escalation in the event of a review not being undertaken. SOT will review compliance reporting from the App, with assurance provided through the Senior Leadership Team (SLT).
			Expected Evidence of Implementation: • Screenshots of automated notification and How To guide. • Copies of reports through the governance routes (AAA reporting from SOT to SLT) on High-Risk Record compliance.
		High Priority	**Officer:** Judith Bryce, Assistant Director of Operations **Target Implementation Date:** December 2026
	Theme: Quality, Safety & Patient Experience	Control Operation	

Objective 3: High Risk Records are used effectively to inform responses and trigger timely protective actions and escalation, with mechanisms to alert staff promptly and training to ensure appropriate identification and response.	**Reasonable**

Review of the High Risk Record Policy and discussion with the Trust confirmed that there is no formalised training module specific to HRRs. Responsibility for staff awareness rests with line managers, who are expected to provide guidance during induction.

Management advised that, operationally, when a call is received from an individual or location associated with an HRR, call handlers are alerted via on-screen prompts within the CAD system. These prompts replicate the information extracted from the HRRIRF. Review of the example screen prompts provided confirmed that HRRs are clearly flagged through an amber-highlighted warning tab. Selecting this tab provides call handlers with relevant risk information, including the alert category and supporting narrative describing the nature of the risk.

This information is used to inform call handling and response decisions, with actions varying depending on the alert category. For example, staff safety risks may prompt the allocation of additional crew or a request for police support; medical alerts or advanced care plans may influence clinical decision-making and convey specific patient management instructions; and access or location-based risks may inform route planning or highlight hazards at the scene.

In terms of communication to responding crews, certain categories of warnings are automatically populated within the dispatch allocation screen. However, for some categories, such as medical alerts and advanced care plans, warnings are not automatically populated due to the volume and complexity of information. In these cases, the Response Coordinator is required to manually input the relevant details. For vehicles equipped with the National Mobilisation Application (NMA), this information is subsequently relayed audibly to crews alongside call information.

While direct observation of live calls and the communication of HRR information to responding crews was not undertaken, this was a deliberate decision as it was considered unlikely that a relevant HRR-related call would occur during the audit observation period, rather than due to a lack of access to the process.

Objective 4: Appropriate access controls, audit trails, and retention/disposal procedures are in place to safeguard confidentiality, and that information sharing with public authorities is lawful, and compliant with data protection standards.	**Reasonable**

A review of user access arrangements identified that a large number of staff have access to the CAD system, reflecting the operational requirement for clinical contact centre personnel. Access is tiered, with different permission levels applied. For example, Operations Managers (OMs) are able to add temporary HRRs prior to completion of the formal HRRIRF.

Analysis of the user access report confirmed that users assigned to "Top User Profile" categories (e.g. Admin and Duty Manager) have the ability to add, edit and remove HRRs. Filtering of this profile identified approximately 175 users with these enhanced access rights.

It was noted that user accounts are intended to be automatically suspended following three months of inactivity. Following discussions with the ICT team, we were advised that a monthly audit is undertaken to identify accounts that have been inactive for three months, as well as those not used within three months of creation. As the Trust does not have the capability to permanently delete accounts, a significant number of disabled and duplicate accounts—often arising from typographical errors—remain on the system in a dormant state.

Detailed testing of role-based access permissions (e.g. the ability to add, amend or remove HRRs) was not undertaken as part of this review. The audit focused on high-level access arrangements and user populations, rather than a comprehensive review of system access controls. We are aware that periodic monitoring is undertaken through the National Intelligent Integrated Audit Solution (NIIAS), an automated tool used to track staff access to patient records and identify potential inappropriate access; however, the operation and effectiveness of these controls were not tested as part of this review.

In addition, as highlighted under Objective 2 (see **Key Finding 6**), a significant number of HRRs had exceeded their review date. This indicates that retention and disposal controls are not consistently applied in practice, increasing the risk of records being retained beyond their intended period.

Discussion with the Data Protection Officer confirmed that the Trust follows the Joint Emergency Services Interoperability Principles (JESIP), which provides guidance for information sharing with partner organisations, such as the police. It was noted that, in relation to HRRs, information sharing is proportionate, in line with Information Commissioner's Office guidance: *Data sharing in an urgent situation or in an* emergency) with only relevant risk information disclosed and patient medical details withheld where not required.

In addition, Information Governance expertise is incorporated into policy development, with an Information Governance lead included in the Task and Finish Group responsible for the development of the updated High Risk Record Policy.

Objective 5: Monitoring mechanisms, including regular audits, are in place to provide assurance that the Trust fulfils its statutory and organisational responsibilities for managing High Risk Records.	**Limited**

As identified in Objective 1, the High Risk Record Policy does not include defined reporting or governance arrangements. This gap in policy design is reflected in practice, as confirmed through discussions with the Trust, which advised that there is currently no designated group or committee through which HRRs are routinely reported or escalated.

A review of the Trust Board and Sub-Committee structures did not identify any forums where HRR activity, risks or trends are formally reported, monitored or subject to scrutiny (see **Key Finding 7)**. As a result, there is limited visibility at a corporate level, reducing the Trust's ability to gain assurance that HRRs are being effectively managed, risks are being identified and addressed in a timely manner, and statutory and organisational responsibilities are being met.

It was recognised that there may be some indirect oversight through related organisational reporting streams, for example frequent callers and violence and aggression reporting through Health and Safety, Operations and People and Culture governance arrangements.

	Key Findings	Risk & Impact	Agreed Management Action
7	**Reporting and Governance Oversight** The High Risk Record Policy does not define formal reporting or governance arrangements. There is currently no defined committee or forum through which HRRs are routinely reported, monitored or escalated. Review of Board and Sub-Committee structures confirmed that HRR activity is not subject to formal oversight or scrutiny.	High Risk Records may not be adequately monitored, challenged, or escalated, reducing oversight and increasing the risk that significant issues are not identified or addressed promptly.	**Agreed Action:** Formal reporting and governance routes for HRR reporting and compliance will be established; This will be reported monthly through SOT with assurance into SLT. **Expected Evidence of Implementation:** SOT and SLT papers and AAA reporting.
		High Priority	**Officer:** Judith Bryce, Assistant Director of Operations **Target Implementation Date:** December 2026
	Theme: Reporting	Control Operation	

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.

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Priority	Explanation
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Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

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

Date issued: June 2026



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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

This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at the Welsh Ambulance Services University NHS Trust (The Trust). We presented our 2026 Audit Plan to the committee in April 2026.

We also provide additional information on:

- other relevant examinations and studies published by the Auditor General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

Accounts audit update

Audit of the Trust's 2025-26 Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance and Corporate Resources
- **Focus of the work:** To provide an audit opinion on the Trust's 2025-26 Annual Report and Accounts.
- **Status:** We received the 2025-26 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 23 June 2026, with Board approval of the Trust's financial statements to follow on 25 June 2026. The Auditor General is scheduled to certify the financial statements on 26 June 2026 ahead of the 30 June 2026 deadline.
- **Expected committee date:** 23 June 2026

Performance audit update

Structured assessment 2024 - Deep dive review of investment in digital systems

- **Executive Lead:** Director of Digital
- **Focus of the work:** This work will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Drafting.
- **Expected committee date:** September 2026

Review of Non-Emergency Patient Transport Service

- **Executive Lead:** Executive Director of Operations
- **Focus of the work:** This review will examine the effectiveness and efficiency of the Trust's Non-Emergency Patient Transport Service, with a particular focus on arrangements for the transfer and discharge function.
- **Status:** Drafting.
- **Expected committee date:** September 2026

Structured assessment 2025 - Deep dive review of the arrangements to manage estates

- **Executive Lead:** Executive Director of Finance and Corporate Resources
- **Focus of the work:** This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Fieldwork.
- **Expected committee date:** September 2026

Structured Assessment 2026

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** The 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources and track progress against previous audit recommendations.
- **Status:** Planning

Expected committee date: December 2026

Review of 111 Service

- **Executive Lead:** Director of Operations
- **Focus of the work:** The local performance audit work will focus on the governance, oversight and performance of the 111 service. This will also include a follow-up of the two recommendations made in our review of urgent and emergency care services at the Trust which reported in 2025.
- **Status:** Planning

Expected committee date: October 2026

Other relevant publications

Over the past three months, the Auditor General has published other relevant outputs which have relevance to the NHS. These are set out below.

NHS planned care – fit for the future?	June 2026
Additional Learning Needs: Do public bodies know if the system is working?	April 2026
Managing the Regional Integration Fund	March 2026

Since the last committee update, Audit Wales has published the following corporate documents:

Annual Plan for 2026-27	April 2026
Strategic Equality Plan 2026-2030	April 2026

There are no relevant Audit Wales consultations currently underway.

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

Visit our website to find:



Our publications which cover our audit work at public bodies.



Information on our upcoming work and forward work programme for performance audit.



Data tools to help you better understand public spending trends.



Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.



Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

Archwilio Cymru
Audit Wales

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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

Agenda Item No.	9

REPORT TITLE

Risk Management and Board Assurance Framework Report

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	23 June 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Governance / Board Secretary
Author(s) of report	Julie Boalch, Assistant Director of Corporate Governance & Risk

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☒ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY:

[See writing and presentation guidance here to inform this section]

1. This report provides assurance on the management of the Trust's principal risks and a high level update against the 2026/27 risk management work programme.

Principal Risk Activity

2. The report demonstrates that the Trust's principal risks continue to be actively reviewed by Directors and the Executive Leadership Team (ELT), in line with the agreed schedule, with assurance provided through committee oversight and the Alert, Assure, Advise (AAA) mechanism.

3. During this reporting period, there has been sustained focus on the Trust's highest rated risks, which remain under close review, with all principal risk activity considered by the ELT on 27 May 2026. Members can be assured that the ELT also received and approved the activity at its meetings on 04 March 2026 and 08 April 2026.

4. The report highlights an increase in score for Risk 223 *The Trust's inability to reach patients in the community causing patient harm and death* from 20 (4x5) to 25 (5x5) reflecting the continued impact of system wide constraints, particularly in relation to handover delays, where risks cannot be fully mitigated by Trust controls alone.

5. Risk 139 *Failure to Deliver our Statutory Financial Duties* has increased in score from 8 (2x4) to 12 (3x4) in line with the financial position for 2026/27 and delivery of the plan being reliant on £9m of savings, with £1.2m yet to be identified, and wider cost pressures such as an increase in fuel costs.

High Level Summary of the 2026/27 Work Programme and Progress

6. Progress in delivering the next phase of the risk management programme for 2026/27 is positive, with development of the following:
    a. Strategic risk aligned to strategic objective 2
    b. Strategic BAF template and BAF dashboard for Board level reporting
    c. Suite of strategic risks aligned to strategic objectives
    d. Thresholds and tolerances aligned to the suite of risk appetite statements
    e. Principal risks mapped to strategic objectives
    f. Design and development of the new ERM

7. Outputs from this work will be considered by the Audit, Risk and Assurance Committee subgroup in August 2026, with a dedicated risk management session planned for the September 2026 committee meeting.

8. The Committee is asked to note progress against the 2026/27 work programme and take assurance on the continued active management and oversight of the Trust's principal risks.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section
The Audit, Risk and Assurance Committee is requested to: • Consider and note the direction of travel for the Trust's risk management programme for 2026/27, including the embedding of Risk Appetite, development of a strategic Board Assurance Framework and enhancement of risk reporting arrangements; • Receive assurance on the continued management and oversight of the Trust's principal risks including their review at the Executive Leadership Team and at relevant committees; and • Note the increase of two principal risk scores for Risk 223 to 25 (5x5) and Risk 139 to 12 (3x4).

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room
The Trust Board is requested to receive the following: **Annex 1** Summary table describing the Trust's Principal Risks **Annex 2** Scoring Matrix **Annex 3** Frequency of Risk Review **Annex 4** Board Assurance Framework (Ibabs Reading Room) **Annex 5** Principal Risk Trending Data

Governance and assurance checks to support decision-making and demonstrate alignment and risk mitigation.

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☒ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
See Annex 1.

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☒ Equitable	☒ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☒ Workforce	☒ Culture
☒ Information	☒ Learning Improvement and Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document here for further details.

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
27 May 2026	Executive Leadership Team
23 June 2026	Audit, Risk & Assurance Committee

SITUATION

1. The purpose of the report is to provide the committee with an update on the management of the Trust's principal risks and an overview of the agreed priorities for the 2026/27 risk management work programme, including activities that will further strengthen the Trust's approach to risk management and assurance.

BACKGROUND

2. Independent oversight and advice on the effectiveness of the Trust's risk management arrangements are provided to the Board and Accountable Officer by the Audit and Risk Assurance Committee (ARAC). The committee operates in a scrutiny and advisory capacity, reviewing the adequacy and reliability of the systems and processes used to identify, assess and manage risk.

3. While the Board retains responsibility for setting risk appetite and ensuring effective governance, ARAC supports this by testing whether arrangements are well designed, operating effectively, and aligned to strategic objectives.

4. The committee also assesses the strength of the assurance framework, drawing on internal and external audit and other sources to confirm that controls are effective and risks are being addressed. It provides constructive challenge on significant and emerging risks, identifies gaps in assurance, and promotes transparent reporting. In doing so, it strengthens governance and supports continuous improvement in organisational risk management.

5. The effectiveness of the Trust's risk management arrangements continues to be supported through ARAC oversight, alongside clear executive ownership of principal risks and routine review through the Executive Leadership Team (ELT) and directorate governance structures.

6. This report evidences the Trust's continued focus on strengthening risk management through regular review and challenge across governance forums and active oversight of mitigation actions.

ASSESSMENT

Risk Management Work Programme 2026/27 - direction of travel

7. At its meeting in March 2026, the committee agreed the priorities for the next phase of the risk management programme. These have been incorporated into the Corporate Governance local delivery plan and will be delivered through a structured programme of work.

8. Over the coming months, the committee can expect a substantive step change in the maturity, integration and presentation of the Trust's risk management and assurance arrangements. The next phase of the programme will focus on:

- Embedding risk appetite including monitoring arrangements
- Implementing a new Electronic Risk Management (ERM) system
- Transitioning to a strategic objective led Board Assurance Framework (BAF) including strategic dashboard reporting for the Trust Board

9. This will be supported by high level dashboards, strengthened risk methodology, and greater insight into risk trends, mitigating actions and their effectiveness.

10. Several outputs from this work will be tested with the ELT in July 2026 and the ARAC Subgroup in August 2026. A dedicated session planned with committee at its meeting in September 2026 will focus on:

- Outline of the new ERM
- Pilot of a strategic risk aligned to strategic objective 2
- Development of a strategic BAF template
- Introduction of a BAF dashboard for Board level reporting
- Development of a suite of strategic risks aligned to strategic objectives
- Alignment of principal risks mapped to strategic objectives
- Strengthening the quality and impact of mitigating actions
- Enhanced use of risk trending data to support oversight and escalation
- Clarification and strengthening of risk management guidance

11. Delivery is being managed through defined milestones, governance and reporting arrangements within the Corporate Governance local delivery plan.

12. Taken together, this programme of work provides a clear and structured approach to strengthening the Trust's risk management and assurance framework, with appropriate oversight and governance in place.

Risk Appetite Statements

13. The suite of Risk Appetite Statements, approved by the Board in November 2025, will be subject to its first annual review in September 2026.

14. The committee will consider whether any refinements are required including the review of appetite levels and expanding coverage to specific areas such as cyber and the use of AI technologies.

15. The next phase of this work will include:
    - Development and testing of a risk appetite dashboard, including thresholds and tolerances
    - Production of guidance to support the application of risk appetite in line with the 2024/25 Internal Audit recommendation
    - Design of monitoring metrics and reporting arrangements to track performance against defined risk appetite levels.

Electronic Risk Management System

16. The Trust has continued to progress the design and development of a new Enterprise Risk Management (ERM). This new system is intended to support an integrated approach to risk management, enabling alignment between strategic and operational risks, improved data quality, and enhanced reporting capability.

17. Further detail and timelines will be provided to the ARAC subgroup; including a demonstration of the system.

18. The development of this new ERM system represents a significant step in the Trust's maturity journey providing a modern, integrated, digital platform to support effective risk management across all levels of the Trust.

Principal Risks

19. The Trust's principal risks, as set out below, are allocated to directors who are responsible for ongoing review and the delivery of agreed mitigating actions. In addition to directorate level reviews, formal risk review discussions are held by the focusing on risk escalation, changes in risk ratings, and the identification of new risks for inclusion on the Corporate Risk Register (CRR).

20. The ELT approved the principal risk activity on 27 May 2026 having considered the review of each risk undertaken throughout the period by risk owners. Members can be assured that the ELT also received the risks and approved the activity at its meetings held on 04 March 2026 and 08 April 2026.

21. A summary table of these risks is set out in Annex 1 with a detailed description of each contained within the Board Assurance Framework (BAF) at Annex 4. All updates are highlighted in blue on the BAF.

22. The more detailed description contained within the BAF provides the Board 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 in Annex 2.

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

24. 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*, have been reviewed in the context of the Trust's operating environment.

25. The ELT approved an increase in the score for Risk 223 from 20 (4x5) to 25 (5x5) which is due to a sustained deterioration in handover lost hours over the last 3 months, exceeding staff capacity, reducing available resources and increasing the risk of delayed patient care and harm.

26. Members will note that the score for Risk 224 has remained static at 25 (5x5) noting that internal controls cannot fully mitigate external system constraints, including Emergency Department capacity, patient flow and inconsistent delivery of national handover standards.

27. While the Trust continues to demonstrate high levels of internal assurance, recent national focus on care standards and system performance provides an opportunity to strengthen consistency and improve the effectiveness of wider system responses. Historic variation in adherence to national handover standards and the delivery of improvement plans has limited the extent of risk mitigation achievable through internal controls alone. However, increasing national scrutiny, and a shift toward system-based accountability continue to present an opportunity to deliver greater consistency and collective impact across organisational boundaries.

28. The risks continue to be reported to the Trust Board, with emphasis on actions within the Trust's control. These are reflected in the avoidable harm dashboard presented at each Board meeting. Further mitigations and transformational actions are also described in the Integrated Medium Term Plan (IMTP) and other regular reports, including the IMTP Assurance Report and the Monthly Integrated Quality & Performance Report to address these risks.

29. Most actions in the avoidable harm dashboard have been completed, and several efficiencies and improvements have contributed to stabilised performance. However, the Trust is cannot fully mitigate the scale of handover lost hours due to the wider system environment.

30. The Quality, Patient Experience and Safety Committee (QuEST) reviewed both risks at its meeting in May 2026 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 AAA report.

31. **Risk 139** *Failure to Deliver our Statutory Financial Duties* has been increased from a score of 8 (2x4) to 12 (3x4) in line with the financial position for 2026/27 which is reliant on £9m savings (incl. £1.2m not yet identified), with additional risk from a sustained increase in fuel costs and wider NHS financial pressures that may require further savings in year.

32. **Risk 201a** *Relationships with Stakeholders* remains static at a score of 16 (4x4). The BAF extract for **Risk 201b** *Poor Patient Experience Affecting Reputation* has not been included in the report before committee today; however, the detail will be presented at the next meeting in September 2026 as it is navigating Trust governance in this next round.

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. The risk is reviewed in private sessions of committees given that the specific detail and planned mitigations of this risk are of a sensitive and security based nature. The high level detail of the risk and its rating is included in public session; however, the full detail is not included in Annex 4. The risk will be discussed in the private session of committee today and has been considered by the private meeting of the Finance & Performance Committee (FPC) on 19 May 2026.

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 public 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. The FPC noted that an independent review

commissioned by the JCC was largely supportive of the Trust's position and ongoing engagement with commissioners continues although timelines on the formal outcome and funding remain uncertain.

35. **Risk 680** *Failure to prioritise people capability and organisational culture could result in deteriorating Employee Experience, reduced wellbeing and absence*, remains static at a score of 16 (4x4) during this review period. This risk considers the resulting adverse impact on workforce capacity and patient safety and which aligns its controls, gaps in controls, and actions against the three Cs of the People and Culture Plan, those being culture, capacity and capability.

36. **Risk 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* remains static at a score of 16 (4x4) and was considered in detail by the FPC in May 2026. Members noted that while the risk retains its high score, mitigation continues to be constrained by capacity limitations.

37. **Risk 671** *Unauthorised or Inappropriate use of AI technologies* and **Risk 690** *SAR and Disclosure of Records Compliance* remains static at a score of 16 (4x4) in this review period.

38. **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* remain unchanged this period and static at a score of 15 (3x5). The ELT acknowledged that all internal actions have been explored and agreed to tolerate the risk at this level for this review period.

39. **Risk 100** *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* remains static at a score of 12 (3x4) during this period; however, a full refresh of the risk is planned.

40. **Risk 163** *Maintaining Effective & Strong Trade Union Partnerships* remains unchanged at a score of 12 (3x4) in this review period.

Risk Trending Data

41. A dashboard describing principal risk score trends from March 2023 and their movement over time has been produced and is attached at Annex 5. A heat map of these risks will be developed once work is completed to map these risks to the overarching strategic risks in development; those that will prevent the Trust from achieving its strategic objectives.

42. The trend data demonstrates where a risk has achieved target score, been fully mitigated or closed and which has then either been removed from the corporate risk register and de-escalated to a directorate risk register for ongoing monitoring or closed from all registers.

43. The use of risk appetite going forward will support a more prescribed interrogation of the risk data as it informs risk scoring, target setting, escalation and assurance mapping of each of the risks.

44. Earlier in the year, Directors each received a dashboard showing the number of mitigating actions against each of the principal risks, their completion dates and the anticipated impact on the target scores. Building on this work, Directors and their teams are asked to discuss risk mitigation with a closer focus on the actions required to achieve target scores and to test whether the risks are well controlled despite scores remaining static as well as the level of risk being carried.

45. As the Trust develops a more strategic approach to the BAF, there is an opportunity to enhance the clarity and usefulness of the reporting to include a dashboard to track the status of actions and their impact on risk scores which could help demonstrate progress more clearly and support more informed oversight.

46. Members can be assured that a system of internal control is in place, risks are actively managed through established processes, and the overall maturity of the risk management programme continues to improve.

RECOMMENDATION

47. The recommendations are as set out in the front cover above.

NEXT STEPS

48. In line with the risk reporting schedule, a detailed review of each principal risk is underway with the outcome reported to the ELT on 08 July 2026 for discussion and approval of the activity.

49. The ARAC subgroup will consider the outputs associated with the direction of travel for the risk management programme in August 2026 with a focused session planned for the next committee meeting on 03 September 2026.

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)** ↑ **20 (4x5)**
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)** →
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	**IF** the Trust has not fully implemented the MAI recommendations AND a major	Executive Director of Operations	**20 (4x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	Manchester 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		
201a Trust Board	Relationships with Stakeholders	**IF** the organisation fails to engage key stakeholders (Welsh Government, Audit Wales, Internal Audit, HIW, Health Boards and Local Authorities) in a meaningful and transparent way **THEN** there will be a lack of stakeholder confidence in our ability to deliver our strategic objectives and system wide goals **RESULTING IN** a weakened strategic influence, impact on funding streams, or escalation arrangements	Director of Partnerships & Engagement	**16 (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 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)** 

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
671 FPC	Unauthorised or Inappropriate use of AI technologies	**IF** staff use Gen-AI tools such as ChatGPT, Co-Pilot or other AI enable platforms outside of approved organisational channels or without appropriate governance **THEN** information passed into, accessed by, or returned by the AI tools may breach information security and data protection controls, and use of the output may breach transparency, medical device, equality, Welsh Language and ethical requirements **RESULTING IN** potential breach of confidentiality and data protection law, data, damage to Trust, and non-compliance with other legislation, regulation and standards.	Director of Digital	**16 (4x4)** →
680 PCC	Failure to prioritise people capability and organisational culture could result in deteriorating Employee Experience, reduced wellbeing and absence.	**IF** insufficient focus on people capability and organisational culture **THEN** will lead to a poor employee experience, low morale, burnout, fatigue, reduced wellbeing and increased sickness absence **RESULTING IN** Adversely impacted workforce capacity, patient safety and the Trust's ability to deliver safe and effective ambulance services	Director of People	**16 (4x4)** →
690 FPC	SAR and Disclosure of Records Compliance	**IF** records requests from patients, the public or staff are not processed consistently or correctly **THEN** inappropriate withholding of information or disclosures may occur		**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN harm to data subjects and financial or reputational damage to the Trust		
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)** →
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)** →
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation.	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)	Executive Director of Finance & Corporate Resources	**12 (3x4)** ↑ **8 (2x4)**

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

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.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	ocal media coverage - short-term reduction in public confidence/trust. 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

Directorate	Risk ID	Risk Title	Strategic Objectiv	Risk Appetit	Jun-24	Sep-24	Nov-24	Mar-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-25	Feb-26	Apr-26	May-26	Risk ID
Operations	223	Trust's inability to reach patients in the community causing patient harm and death	1	Open	25	25	25	25	25	25	25	25	25	20	20	20	20	25	223
Quality & Nursing	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	1	Open	25	25	25	25	25	25	25	25	25	25	25	25	25	25	224
Digital Services	260	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	3	Keen	15	15	15	20	20	20	20	20	20	20	20	20	20	20	260
Operations	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	1	Open				20	20	20	20	20	20	20	20	20	20	20	641
People & Culture	160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	2	Open	20	20	20	20	20	20	16	16	16	16	16	16			160
Digital Services	671	Unauthorised or inappropriate use of AI technologies	3	Keen							16	16	16	16	16	16	16	16	671
Finance and Corporate Resources	542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan	6b	Open	16	16	16	16	16	16	16	16	16	16	16	16	16	16	542
Partnership and Engagement	201a	Relationships with Stakeholders	5	Open									16	16	16	16	16	16	201a
Quality & Nursing	201b	Poor Patient Experience Affecting Reputation	4	Open									16	16	16	16	16	16	201b
People & Culture	680	Deteriorating Employee Experience and Workforce Capacity due to underinvestment in people and organisational culture	4	Open													16	16	680
Operations	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	1	Open	20	20	15	15	15	15	15	15	15	15	15	15	15	15	594
People & Culture	558	Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures	2	Open	15	15	15	15	15	15	15	15	15	15	15	15			558
Digital Services	620	Symptom Checkers	1	Open				20	15	15	15	15	15	15	15	15	15	15	620
Digital Services	690	SAR and Disclosure of Records Compliance	3	Keen													16	16	690
People & Culture	163	Maintaining Effective & Strong Trade Union Partnerships	2	Open	16	16	12	12	12	12	12	12	12	12	12	12	12	12	163
Strategy, Planning & Performance	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	4	Open	12	12	12	12	12	12	12	12	12	12	12	12	12	12	100
Finance and Corporate Resources	139	Failure to Deliver our Statutory Financial Duties in accordance with legislation	6a	Cautious	8	8	8	8	8	8	8	8	8	8	8	8	8	12	139
Partnership and Engagement	201	Damage to Trust reputation following a loss of stakeholder confidence			20	20	20	20	20	20	20	20							201
Strategy, Planning & Performance	458	A confirmed commitment from JCC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning																	458
Operations	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																	245
People & Culture	557	Potential impact on services as a result of Industrial Action																	557
Digital Services	543	Major disruptive incident resulting in a loss of critical IT systems			10														543
Quality & Nursing	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																	199
Operations	244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service																	244
Strategy, Planning & Performance	424	Prioritisation or Availability of Resources to Deliver the Trust's IMTP			12	8													424
Operations	283	Failure to implement the EMS Operational Transformation Programme																	283
Digital Services	623	Failure to comply with Data Protection Legislation	5	Open	15	15	15	15	15	15	15	15	15	10					623
Quality & Nursing	637	Diesel Fumes																	637
Digital Services	538	Digital System Implementation																	538

	Risk achieved target score and de-escalated to directorate level for ongoing monitoring
	Risk closed from all registers
	Risk not in existence

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Welsh Ambulance Services
University NHS Trust

Agenda Item No.	10

REPORT TITLE

Audit Tracker – 2025/26 Q4 Reporting and Update

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	23 June 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Lisa Trounce, Head of Compliance and Assurance

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☐ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY:

[See writing and presentation guidance here to inform this section]

1. This report provides the Audit, Risk and Assurance Committee (ARAC) with an overview of audit activity and the implementation of internal and external audit recommendations during Quarter 4 of 2025/26. It also outlines the proposed revised audit reporting arrangements following the migration to Audit Tracker 3.0 and the ongoing development of Power BI reporting functionality.

2. The report provides reasonable assurance that the Trust's arrangements for monitoring and implementing audit recommendations continue to mature. Enhanced audit tracking strengthened evidence requirements and improved reporting arrangements have increased organisational visibility of audit recommendations and supported greater accountability for their delivery. A reasonable assurance follow-up review provides assurance that management actions are being implemented and embedded effectively.

3. The Trust's audit programmes continue to be developed on a risk-based basis, informed by organisational objectives, principal risks and regulatory requirements, and are subject to scrutiny through the Executive Leadership Team and ARAC. During 2025/26, the profile of internal audit opinions improved, with an increase in Substantial and Reasonable Assurance ratings and no Limited Assurance reports issued during the year.

4. As at Quarter 4 year-end, there were 23 open internal audit reports comprising 62 open audit actions, alongside five open external audit reports comprising 12 open actions. Progress continues to be made in implementing recommendations, although a proportion of actions have required revised implementation dates. Where implementation has been delayed, assurance has been sought regarding mitigating controls and the management of associated risks.

5. The report proposes a revised, proportionate approach to audit reporting, with ARAC receiving bi-annual strategic oversight reports supported by access to real-time audit information via Audit Tracker 3.0, while committees receive quarterly exception reports focused on high-risk and overdue actions within their respective remits.

6. The Committee is asked to note the progress reported, take assurance from the arrangements in place to monitor the implementation of audit recommendations, and consider the proposed revised reporting arrangements.

7. Highlights at a glance:

    - 23 Open internal audit reports
    - 62 Open internal audit actions
    - 6 internal audit actions closed in Q4
    - 5 Open external audit reports
    - 12 Open external audit actions
    - 21 Revised dates applied in quarter
    - 0 Limited assurance audits in 2025/26

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Audit, Risk and Assurance Committee (ARAC) is requested to:

1. **Note** the progress of the internal audit activity during Quarter 4 of 2025/26 financial year;
2. **Endorse** the revised audit reporting approach; and
3. **Receive** assurance that the management actions for the audits within the purview of this committee, and overall, are being effectively and appropriately managed, closed off in quarter or the rationale provided for revised dates applied.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

The Audit, Risk and Assurance Committee is requested to receive the following:

Annex 1 2526 Q4 (Jan-Mar26) ARAC Actions Only - For ARAC 230626 (Public)

Governance and assurance checks to support decision-making and demonstrate alignment and risk mitigation

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☐ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☒ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☐ Equitable	☐ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☒ Workforce	☐ Culture
☒ Information	☐ Learning Improvement and Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document here for further details.

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
n/a	n/a

SITUATION

1. This paper provides the Audit, Risk and Assurance Committee (ARAC) with an update on audit activity for Quarter 4 of the 2025/26 financial year. The report also outlines the proposed revised approach to audit reporting as agreed at a previous committee meeting, following the transition to Audit Tracker 3.0 (SharePoint List) and the introduction of Power BI reporting capability (this is in development).
2. The report is intended to support the committee in discharging its responsibilities by:

    - Providing assurance on the adequacy and effectiveness of the organisation's internal governance control framework in relation to internal and external audit
    - Monitoring the timely implementation of agreed management actions to mitigate the risks identified via internal and external audit recommendations
    - Proposing more streamlined reporting

3. Overall, the report provides reasonable assurance that arrangements for monitoring and implementing audit recommendations continue to mature, with improved visibility, accountability and oversight across the organisation. Whilst a number of audit actions remain open, there are no matters identified within this reporting period which indicate a significant deterioration in the organisation's control environment. Areas where implementation dates have been extended are highlighted within the report together with the mitigating actions in place.

BACKGROUND

4. During 2025/26 financial year, the Audit Tracker was migrated to Audit Tracker 3.0, a SharePoint List-based system. This transition has enabled improved data quality, real-time visibility of audit actions, and enhanced reporting capability through Power BI dashboards. There has been some delay in producing Power BI dashboards due to capacity, however this will continue to be progressed in the next two quarters.

ASSESSMENT

Revised Reporting

5. The Trust has continued to strengthen its arrangements for audit oversight and the monitoring of management actions arising from both internal and external audit reviews.

6. There is evidence of increasing maturity in the management of audit actions, with directorates demonstrating improved ownership of recommendations and greater focus on evidencing implementation and impact. The reasonable assurance follow-up review - on the agenda for this meeting - provide assurance that management actions are being embedded and operating as intended, and that actions are being appropriately closed down.

7. Whilst the strengthened assurance arrangements have improved the quality of evidence supporting action closure, there remains a need to ensure that processes remain proportionate. As evidence requirements become more detailed, there is a risk that closure of actions may take longer to achieve. It is therefore important that assurance requirements continue to be balanced against the need for timely implementation and closure of recommendations.

8. The Trust is now well placed to transition to the next phase of maturity in its audit oversight arrangements. In addition to the revised reporting proposed below, a delivery group in the internal governance structures will provide a mechanism for the escalation and resolution of barriers to implementation, supporting continued progress in the delivery and closure of audit recommendations.

9. All committees with audit recommendations have been receiving the full tracker and indicating rates of closure, moved dates, and areas of risk. It is proposed that now transitions to a more focused assurance paper on actions that are either high priority, or that arise from a limited assurance audit, that are on their final revised date. That effectively provides that internal governance arrangements manage movement of a first revised date, and that directors attend the relevant committee when a final revised date is proposed. This will provide the committee with assurance that final dates are realistic and that risk has not increased due to delays. This was trialled in Q1 for the Finance and Performance, People and Culture, and the Quality, Patient Experience and Safety Committees to good effect.

10. This development represents a more proportionate reporting model, ensuring that oversight is strengthened while reporting remains focussed and risk-based.

    Under the new model, committees that have audit actions will receive:

    - List of audits with open actions showing year of audit
    - Link to Siren page where internal audit reports are uploaded
    - High-priority findings with actions on final revised date
    - Any limited assurance actions on final revised date
    - Detail to include:
        - Name of audit
        - Date of audit
        - Key finding
        - Action agreed showing original and revised dates
        - Evidence agreed
        - Progress update
        - Assurance on delivery and that risk is not increased by amended dates

    For the Audit, Risk and Assurance Committee a further bi-annual report is proposed, incorporating:

    - Number of audits per year with ratings
    - Number of audits per committee oversight including actions met first, second or final dates
    - Audit plan progressing (via the Internal Audit Progress Report)
    - Progress of management actions (via the Internal Audit Progress Report)
    - Assurance that audit plans are risk based (developed by ELT and endorsed by ARAC)

    This approach ensures that detailed oversight is maintained at ARAC level, while enabling committees to focus on the most significant risks and exceptions relevant to their remit.

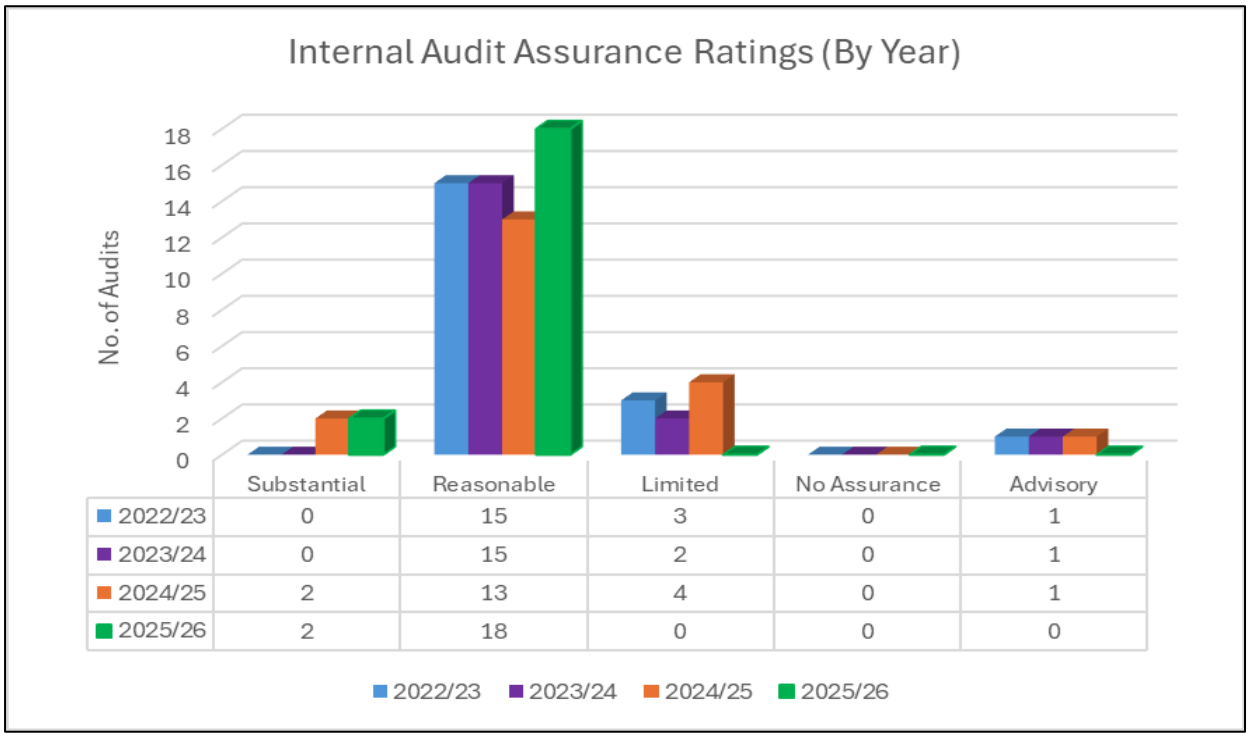
INTERNAL AUDIT

Internal Audit – Audit Plans, Assurance and Actions

11. The Trust continues to ensure that its internal and external audit programmes are risk-based and aligned to organisational priorities. Audit plans are developed in consultation with the Executive Leadership Team (ELT), taking account of strategic objectives, principal risks, regulatory requirements, emerging issues and areas of known concern. This approach helps ensure that finite audit resources are directed towards those areas presenting the greatest risk to the achievement of

the Trust's objectives. The resulting audit plans are subject to review and scrutiny by relevant committees, as well as this committee, providing assurance that the planned programme of work is appropriate, proportionate and focused on the areas of highest organisational risk.

12. As depicted in the graph below, during 2025/26 the Trust has seen an increase in internal audits in substantial and reasonable assurance ratings. There were no internal audit reports with limited assurance rating this year which is extremely positive.



	Substantial	Reasonable	Limited	No Assurance	Advisory
2022/23	0	15	3	0	1
2023/24	0	15	2	0	1
2024/25	2	13	4	0	1
2025/26	2	18	0	0	0

13. Whilst assurance ratings should not be viewed in isolation, the improving profile of audit opinions provides a positive indication that control arrangements are continuing to mature across a number of areas of the organisation. However, management attention remains focused on ensuring that recommendations arising from high-priority actions and all actions in limited assurance reviews are implemented in a timely manner and that the associated risks are effectively mitigated.

14. The position regarding open audits and actions as at the end of 2025/26 Q4 is summarised below:

Committee	No. of Open Audit Reports	No. of Actions Closed in Qtr	No. of Open Audit Actions
Audit, Risk and Assurance	0	0	0
Quality, Patient Experience and Safety	7	1	17
Finance and Performance	9	1	20
People and Culture	7	4	25
Total	**23**	**6**	**62**

Internal Audit - Implementation of Audit Actions

15. Timely implementation of agreed audit recommendations remains essential to reducing exposure to identified risks and strengthening the organisation's control environment. Delays in implementation may indicate resource pressures, competing organisational priorities or greater complexity than originally anticipated.

16. Where implementation dates are revised, assurance must be provided that appropriate mitigating controls remain in place and that the level of risk exposure has not materially increased. The revised reporting arrangements proposed below are intended to support more effective oversight of these matters by governance committees.

17. During Q1 committees have been notified of those audit actions that are high priority in nature, or from a limited assurance audit, that are on their final dates and provided assurance from the director that the dates are achievable and that the risk profile is not increased.

AUDIT WALES AND EXTERNAL REPORTS

Delivery of External Audit Actions

18. At the beginning of 2025/26 Quarter 4, there were four external reports which were open on the Audit Tracker 3.0:

- Quality Governance Follow Up Review 2023/24
- Welsh Risk Pool (WRP) Concerns Assessment 2024

- Unscheduled Emergency Care Arrangements for Managing Demand – WAST (April 2025)
- Structured Assessment 2025

19. Of the thirty external audit actions which were open, 18 have been proposed for closure: eight confirmed as closed in quarter, and ten closed pending imminent supply of evidence.

20. The breakdown of external audit actions which remain open by committee is as follows:

Committee	No. of Open Audit Reports	No. of Actions Closed in Qtr	No. of Open Audit Actions
Audit, Risk and Assurance	1	0	2
Quality, Patient Experience and Safety	3	18	8
Finance and Performance	1	0	2
People and Culture	0	0	0
Total	**5**	**18**	**12**

21. Of the remaining 12 open external audit actions relating to all committees, three are due for completion in 2026/27 Quarter 1, one in Quarter 2, and the remaining four actions have now all been scheduled for completion by the end of Quarter 4 as they are dependent upon the Digital Work Plan.

22. The one remaining open external audit report relating to this committee is the 2025 Structured Assessment which has two open actions. As shown in the summary provided overleaf, both actions are due for completion in 2025/26 Quarter 2.

Year	Recommendation	Directorate	Audit Tracker ID	Original Deadline	Revised Deadline
25/26	2025 Structured Assessment	Corporate Governance	134	31/07/26	n/a
			135	30/04/26	n/a

23. Further details on these audit actions can be found in Annex 1.

24. Should any action be assigned a final revised date, they will be escalated in line with the reporting proposed.

25. The reduction in the number of open external audit actions during the quarter represents positive progress. Progress against the remaining actions will continue to be monitored through Audit Tracker 3.0 and reported via the relevant governance committees.

26. There is an action under the remit of this committee related to the 2025 Structured Assessment regarding the policy transformation programme. The recommendation was:

    The Trust should update its policy on policies to make the review process more efficient and practical. This should include clearer steps and methods to convert policies into other types of written control documents (such as procedures or guidelines), where this better reflects their purpose and use.

    After consideration of capacity both in the Corporate Governance Team and more widely in the organisation for this level of change it is proposed this is deferred. Instead, a new and more simplified policy template is being developed with refreshed guidance on its use and proposing new approval routes. This will come through to this committee in September 2026.

RECOMMENDATION

27. Recommendations are detailed on the front cover of this report.

NEXT STEPS

28. Pending ARAC agreement, continue implementation of the revised reporting cycle, with quarterly exception reporting to the other governance committees.

29. Ongoing development and refinement of Power BI dashboards to enhance audit insight and accessibility.

30. Interrogation of the NWSSP Internal Audit database with a view to drawing out elements of the intelligence available, for example: differentiating between recommendations relating to process design versus application.

31. Internal Audit and Audit Wales will continue to provide independent assurance to ARAC and support the organisation in maintaining a robust and effective audit control environment.

Welsh Ambulance Services University NHS Trust

AUDIT TRACKER 3.0 - 2025/26 Q4 UPDATES - ARAC ACTIONS (ARAC 230626) Public

ID	Audit Tracker 2.0 Action Ref.	Year / Audit Plan	Audit Type	Committee Assigned	Public or Private Committee	Report Title v2	Assurance Rating	Responsible Officer	Director	Directorate Point Of Contact (PoC)	Priority Level	Rec. No. in Audit Report	Recommendation	Action No. In Mngt Response	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	Action Status
134	n/a	25/26	Audit Wales	ARAC	Public	Structured Assessment	Not Set	Trish Mills (Welsh Ambulance Servic	Trish Mills	Trish Mills (Welsh Ambulance Service NHS Tr	Not Set	2	The Trust should update its policy on policies to make the review process more efficient and practical. This should include clearer steps and methods to convert policies into other types of written control documents (such as procedures or guidelines), where this better reflects their purpose and use(Paragraph 14).	2	**Accepted.** A policy transformation programme will be scoped out in Q4 of 2025/26. That programme will be reviewed by ARAC in Q1 2026/27 and overseen by them thereafter. Propose closing this item when that programme has been endorsed by ARAC and implementation and timelines agreed for their continued monitoring.	31/07/2026	Not Yet Due	Open
135	n/a	25/26	Audit Wales	ARAC	Public	Structured Assessment	Not Set	Trish Mills (Welsh Ambulance Servic	Trish Mills	Trish Mills (Welsh Ambulance Service NHS Tr	Not Set	3	To strengthen strategic risk oversight, the Trust should ensure that BAF papers provide a clear, high-level summary of changes to risk scores over time. This should be accompanied by an up-to-date view of associated actions, including their current status and any slippage (Paragraph 30).	3	**Accepted.** The summary of changes to risk scores is included in Trust Board papers and will be incorporated into committee papers. Action updates are highlighted in each of the principal risks on the BAF currently, however a section will be added to the risk SBARN to include a high level commentary on the status of actions.	30/04/2026	Not Yet Due	Open

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Agenda Item No.	11

REPORT TITLE

Losses and Special Payments – Payment for the period 1 April 2025 to 31 May 2026

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	23 June 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Chris Turley, Executive Director of Finance and Corporate Resources
Author(s) of report	Madrun Parry-Jones, Deputy Head of Financial Accounting

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☐ Discussion
☐ Information (goes in consent items)	☒ Noting

REPORT SUMMARY:

[See writing and presentation guidance here to inform this section]

1. In accordance with SFI's this report presents to the Committee details of Losses and Special Payments made during the twelve months from 1 April 2025 to 31 March 2026 (**Annex 1**) and during the two months from 1 April 2026 to 31 May 2026 (**Annex 2**).

2. Total net Losses and Special Payments made were as follows:
   - Period 1 April 2025 to 31 March 2026 - -£2.433m
   - Period 1 April 2026 to 31 May 2026 - £0.179m

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Audit, Risk and Assurance Committee is requested to:

1. Note the Losses and Special Payments Report for this period.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

The Audit, Risk and Assurance Committee is requested to receive the following:

Annex 1 Summary and details of payments made for the twelve months to 31 March 2026

Annex 2 Summary and details of payments made for the two months to 31 May 2026

Governance and assurance checks to support decision-making and demonstrate alignment and risk mitigation

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
n/a

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☒ Equitable	☒ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☒ Workforce	☒ Culture
☒ Information	☒ Learning Improvement and Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document here for further details.

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
n/a	n/a

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 1 April 2025 to 31 March 2026 (**Annex 1**) and the two months form 1 April 2026 to 31 May 2026 (**Annex 2**).

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1 April 2025 to 31 March 2026 amounted to -£2.433 million and for the period 1 April 2026 to 31 May 2026 amounted to £0.179 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 31 March 2026 reimbursements received exceeded payments made by £2.433m. However, during the two months to 31 May 2026 payments exceeded reimbursements by £0.179m.

5. During February 2026, WRP reimbursements totalled £0.547m. The majority of this reimbursement related to two cases, amounting to £0.295m and £0.114m respectively. Both cases relate to clinical negligence claims.

6. During April 2026, a positive balance is shown against the WRP Refund line. This relates to coroner costs that were incorrectly claimed on a case, as these costs are not reimbursable under the scheme therefore, a refund has been processed.

RECOMMENDATION

7. Note the Losses and Special Payments Report for this period.

NEXT STEPS

8. To continue to monitor Losses and Special payments.

Welsh Ambulance Services University NHS Trust
Losses and Special Payments

Annex 1

Summary of payments for the twelve months to 31st March 2026

	£
April 2025	-£1,314,358.67
May 2025	£66,430.59
June 2025	-£649,094.89
July 2025	£85,183.56
August 2025	£18,692.24
September 2025	£64,838.74
October 2025	-£189,746.31
November 2025	£150,253.71
December 2025	-£258,552.21
January 2026	£47,443.59
February 2026	-£499,983.73
March 2026	£46,100.58
	-£2,432,792.80

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	141,100.00	58,600.00	4,318.00	3,200.00	7,972.00	111,664.86	18,050.00	5,349.00	1,048.80	17,294.60	558,314.62
Counsel fees		3,570.00	750.00	28,575.00	3,996.45	5,410.00	500.00	3,380.00	7,650.00	3,851.89	312.50	2,075.00	1,400.00	61,470.84
CRU		0.00	-2,412.50	5,177.00	913.00	3,636.00	0.00	-1,517.00	-2,892.00	0.00	-169.00	806.00	788.00	4,329.50
Damages		15,375.00	2,241.00	149,910.00	500.00	-19,229.33	22,649.33	40,474.15	-19,773.38	61,500.00	7,876.72	14,400.00	19,600.00	295,523.49
Defence Costs		12,678.08	-5,327.38	8,773.00	7,505.53	3,956.46	4,942.83	9,500.00	12,726.25	33,025.00	7,356.71	15,593.75	23,916.21	134,646.44
Expert Witness		11,405.00	2,930.00	7,490.00	7,500.00	2,900.00	6,210.00	4,647.80	7,827.00	4,120.00	2,960.00	4,110.00	2,250.00	64,349.80
Vehicle Repairs		21,074.64	18,212.91	20,240.59	6,168.58	23,651.11	23,155.08	26,413.30	33,050.98	6,388.65	23,757.66	4,877.21	14,486.04	221,476.75
WRP Refund		-1,518,526.19	0.00	-1,020,108.43	0.00	-7,520.00	3,496.50	-282,885.45	0.00	-387,537.75	0.00	-547,159.06	-38,034.50	-3,798,274.88
Property Repairs		395.00	0.00	9,747.95	0.00	1,570.00	685.00	2,268.89	0.00	2,050.00	0.00	4,264.57	4,400.23	25,381.64
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**	**-£649,094.89**	**£85,183.56**	**£18,692.24**	**£64,838.74**	**-£189,746.31**	**£150,253.71**	**-£258,552.21**	**£47,443.59**	**-£499,983.73**	**£46,100.58**	**-£2,432,792.80**

22RT4PI0006

Welsh Ambulance Services University NHS Trust	**Key**	
Losses and Special Payments	MN	Medical Negligence
	PI	Personal Injury
Summary of payments for the twelve months to 31st March 2016	DP	Damage To Property
	£	
DP cases < £1,000	28,631.94	69 Cases
Redress cases < £1000	2,993.00	7 Cases
PI cases < £1000	10,682.00	16 Cases
21BT4MN2009	302,165.00	
18BT4MN2012	107,776.00	
24BT4MN2021	30,321.00	
24BT4MN2013	30,720.00	
23BT4MN2004	48,275.00	
22BT4MN2018	37,188.00	
22BT4PI2006	32,381.16	
24BT4MN2004	30,000.00	
24BT4MN2005	24,000.00	
24BT4PI2002	23,886.66	
21BT4PI2021	22,580.00	
24BT4GN2005	22,000.00	
24BT4EQ2002	18,600.00	
23BT4EQ2010	15,400.00	
24BT4PI2045	15,379.32	
22BT4DP0046	14,813.66	
18BT4MN2016	14,633.80	
21BT4MN2030	13,453.91	
24BT4PI2016	12,298.80	
21BT4PI2020	11,500.00	
22BT4MN2019	10,900.00	
24BT4EQ2034	10,500.00	
24BT4MN2008	10,000.00	
24BT4PI2028	9,601.00	
23BT4PI2023	9,546.00	
23BT4PI2020	9,274.31	
24BT4PI2047	9,149.00	
23BT4PI2004	9,109.80	
24BT4DP0090	8,868.82	
23BT4DP0081	8,081.92	
21BT4MN2023	7,450.00	
24BT4DP0115	7,294.94	
23BT4MN2003	6,775.00	
23BT4GN2013	6,600.00	
24BT4DP0068	6,482.25	
24BT4DP0119	6,463.23	
24BT4PI2054	6,038.00	
24BT4DP0080	5,993.86	
23BT4MN2020	5,992.50	
23BT4EQ2025	5,850.00	
24BT4EQ2035	5,500.00	
24BT4DP0034	5,436.60	
23BT4MN2016	5,136.90	
24BT4EQ2027	5,083.75	
24BT4DP0024	5,068.10	
24BT4EQ2033	5,000.00	
23BT4MN2007	4,959.00	
24BT4GN2027	4,800.00	
23BT4EQ2016	4,795.24	
24BT4DP0025	4,782.00	
24BT4DP0036	4,756.98	
24BT4DP0035	4,732.38	
24BT4DP0096	4,603.65	
24BT4EQ2018	4,550.00	
24BT4EQ2016	4,505.00	
22BT4PI2001	4,500.00	
24BT4DP0010	4,498.76	
22BT4DP0040	4,410.65	
24BT4DP0123	4,400.29	
24BT4DP0116	4,282.11	
23BT4GN2028	4,100.00	
24BT4DP0069	4,037.32	
24BT4EQ2031	4,000.00	
24BT4PI2024	3,876.00	
23BT4MN2004	3,740.00	
24BT4DP0111	3,627.83	
22BT4DP0053	3,516.00	
24BT4EQ2015	3,500.00	
24BT4PI2023	3,428.00	
24BT4DP0021	3,370.91	
23BT4MN2022	3,350.00	
24BT4DP0125	3,302.75	
24BT4MN2014	3,276.60	
24BT4PI2021	3,274.00	
24BT4DP0066	3,274.00	
24BT4DP0076	3,251.65	
24BT4DP0033	3,170.92	
22BT4DP0107	3,129.75	
24BT4DP0023	3,108.92	
24BT4DP0054	3,106.91	
24BT4DP0092	3,096.73	
24BT4EQ2022	3,000.00	
24BT4EQ2040	3,000.00	
24BT4DP0066	2,978.65	
24BT4MN2002	2,970.00	
24BT4EQ2026	2,950.00	
23BT4EQ2020	2,950.00	
24BT4DP0087	2,863.98	
24BT4DP0086	2,812.56	
24BT4DP0033	2,808.00	
24BT4DP0017	2,750.00	
24BT4DP0018	2,750.00	
24BT4DP0008	2,745.16	
23BT4PI2018	2,745.00	
24BT4DP0044	2,709.00	
24BT4DP0019	2,687.10	
24BT4DP0056	2,647.79	
24BT4GN2034	2,590.00	
24BT4MN2015	2,560.00	
24BT4EQ2028	2,500.00	
23BT4MN2021	2,430.00	
24BT4DP0067	2,404.14	
24BT4EQ2003	2,382.05	
24BT4EQ2039	2,359.64	
24BT4PI2005	2,288.77	
24BT4DP0077	2,281.72	
24BT4DP0088	2,268.99	
24BT4EQ2008	2,250.00	
24BT4DP0006	2,246.39	
24BT4GN2045	2,200.00	
24BT4EQ2040	2,180.93	
24BT4DP0023	2,059.16	
24BT4DP0067	2,050.00	
24BT4DP0079	2,031.36	
24BT4DP0064	2,018.22	
24BT4DP0100	2,007.97	
23BT4MN2031	2,000.00	
21BT4MN2028	2,000.00	
24BT4EQ2007	2,000.00	
24BT4GN2001	2,000.00	
24BT4EQ2012	1,996.40	
24BT4DP0074	1,970.80	
24BT4DP0106	1,965.85	
24BT4DP0057	1,938.67	
24BT4GN2020	1,920.00	
24BT4DP0102	1,911.87	
24BT4DP0027	1,875.50	
24BT4DP0029	1,848.31	
24BT4DP0082	1,811.26	
24BT4DP0085	1,776.31	
23BT4DP0011	1,759.94	
24BT4DP0116	1,756.94	
24BT4EQ2038	1,756.00	
24BT4EQ2047	1,750.00	
24BT4DP0099	1,668.23	
24BT4PI2041	1,663.00	
24BT4DP0121	1,649.98	
24BT4DP0052	1,630.00	
24BT4PI2048	1,625.00	
22BT4GN2032	1,600.00	
22BT4GN2043	1,600.00	
24BT4GN2040	1,600.00	
24BT4GN2043	1,600.00	
24BT4DP0020	1,570.85	
24BT4PI2008	1,550.00	
23BT4MN2017	1,500.00	
23BT4DP0091	1,500.00	
24BT4EQ2004	1,500.00	
24BT4EQ2019	1,500.00	
24BT4EQ2035	1,500.00	
24BT4EQ2043	1,500.00	
24BT4EQ2044	1,500.00	
24BT4MN2010	1,500.00	
24BT4PI2004	1,500.00	
24BT4MN2017	1,470.60	
24BT4DP0104	1,466.54	
21BT4MN2027	1,448.00	
24BT4DP0075	1,438.48	
24BT4DP0059	1,397.84	
23BT4DP0022	1,259.95	
24BT4EQ2024	1,250.00	
24BT4DP0091	1,250.00	
24BT4EQ2017	1,250.00	
24BT4EQ2029	1,250.00	
24BT4EQ2046	1,250.00	
24BT4DP0114	1,217.31	
24BT4DP0001	1,216.46	
24BT4DP0001	1,120.00	
24BT4EQ2014	1,080.00	
24BT4DP0041	1,077.80	
24BT4GN2030	1,000.00	
24BT4PI2009	1,000.00	
24BT4EQ2006	1,000.00	
24BT4EQ2011	1,000.00	
24BT4EQ2041	1,000.00	
24BT4EQ2042	1,000.00	
24BT4GN2002	1,000.00	
23BT4MN2018	913.00	
23BT4MN2014	910.00	
22BT4MN2016	270.00	
24BT4MN2009	168.32	
23BT4MN2001	130.78	
24BT4MN2024	100.00	
24BT4MN2007	75.93	
24BT4MN2028	58.12	
24BT4MN2016	50.60	
24BT4MN2006	31.17	
24BT4MN2025	30.00	
24BT4PI2026	30.00	WRP REIMBURSEMENT
24BT4GN2013	300.00	WRP REIMBURSEMENT
24BT4GN2017	300.00	WRP REIMBURSEMENT
24BT4GN2030	300.00	WRP REIMBURSEMENT
24BT4GN2031	500.00	WRP REIMBURSEMENT
24BT4GN2039	500.00	WRP REIMBURSEMENT
24BT4GN2044	500.00	WRP REIMBURSEMENT
24BT4GN2038	800.00	WRP REIMBURSEMENT
24BT4MN2018	913.00	WRP REIMBURSEMENT
24BT4GN2036	975.00	WRP REIMBURSEMENT
24BT4GN2012	1,000.00	WRP REIMBURSEMENT
23BT4GN2002	1,000.00	WRP REIMBURSEMENT
23BT4GN2043	1,100.00	WRP REIMBURSEMENT
24BT4GN2001	2,000.00	WRP REIMBURSEMENT
24BT4PI2027	2,125.00	WRP REIMBURSEMENT
24BT4GN2020	2,275.00	WRP REIMBURSEMENT
23BT4GN2027	2,400.00	WRP REIMBURSEMENT
24BT4GN2029	2,800.00	WRP REIMBURSEMENT
24BT4GN2027	3,200.00	WRP REIMBURSEMENT
24BT4PI2031	3,274.00	WRP REIMBURSEMENT
24BT4PI2033	3,428.00	WRP REIMBURSEMENT
23BT4GN2005	3,800.00	WRP REIMBURSEMENT
23BT4GN2020	3,800.00	WRP REIMBURSEMENT
24BT4PI2034	3,874.00	WRP REIMBURSEMENT
23BT4GN2013	5,000.00	WRP REIMBURSEMENT
24BT4GN2036	8,500.00	WRP REIMBURSEMENT
24BT4MN2008	10,296.82	WRP REIMBURSEMENT
23BT4GN2028	10,910.00	WRP REIMBURSEMENT
24BT4PI2032	11,923.00	WRP REIMBURSEMENT
24BT4PI2020	20,045.00	WRP REIMBURSEMENT
24BT4GN2005	22,000.00	WRP REIMBURSEMENT
24BT4GN2026	24,750.00	WRP REIMBURSEMENT
23BT4MN2004	26,538.50	WRP REIMBURSEMENT
21BT4PI2006	29,450.00	WRP REIMBURSEMENT
21BT4PI2026	31,138.86	WRP REIMBURSEMENT
22BT4PI2046	31,198.86	WRP REIMBURSEMENT
23BT4MN2011	35,734.50	WRP REIMBURSEMENT AND REFUND (incorrectly coded corrected in yr -22,628.00)
19BT4PI2017	38,264.58	WRP REIMBURSEMENT
23BT4MN2018	50,892.78	WRP REIMBURSEMENT
24BT4MN2013	76,410.00	WRP REIMBURSEMENT
23BT4PI2028	89,481.00	WRP REIMBURSEMENT
24BT4PI2022	97,489.43	WRP REIMBURSEMENT
22BT4MN2022	170,170.87	WRP REIMBURSEMENT AND Refund from BCU -58,500
18BT4MN2012	295,681.50	WRP REIMBURSEMENT
18BT4MN2016	352,238.76	WRP REIMBURSEMENT
16BT4MN2009	961,854.78	WRP REIMBURSEMENT
22BT4MN2001	1,450,963.39	WRP REIMBURSEMENT
	-	
	-	
Total	**2,432,792.89**	

Welsh Ambulance Services University NHS Trust
Feb-26

Case Reference	Details	Amount (£)
1374732065	EXPERT WITNESS	1,200.00
1385626613	COUNSEL FEES	2,075.00
1378022412	EXPERT WITNESS	490.00
1378022839	EXPERT WITNESS	980.00
1377297483	DEFENCE COSTS	2,000.00
1385628661	EXPERT WITNESS	1,440.00
1376345221	DAMAGE TO PROPERTY	636.74
1376345775	DAMAGE TO VEHICLE	250.00
1377298028	DAMAGE TO VEHICLE	275.00
1377446388	PROFESSIONAL FEES	1,000.00
1381421374	PROFESSIONAL FEES	1,000.00
1381480925	DAMAGE TO PROPERTY	3,115.89
1381512705	DAMAGE TO VEHICLE	843.20
1382486921	DAMAGE TO VEHICLE	56.27
1381957709	DAMAGE TO VEHICLE	149.99
1382484348	PROFESSIONAL FEES	1,500.00
1383389544	DAMAGE TO PROPERTY	511.94
1383390016	PROFESSIONAL FEES	1,093.75
1383604036	PROFESSIONAL FEES	1,500.00
1383604961	PROFESSIONAL FEES	4,500.00
1384144121	PROFESSIONAL FEES	3,000.00
1385612920	DAMAGE TO VEHICLE	3,302.75
NAT11FEB2604	WRP REIMBURSEMENT	- 31,138.40
NAT11FEB2604	WRP REIMBURSEMENT	- 294,852.50
NAT11FEB2604	WRP REIMBURSEMENT	- 47,454.29
NAT11FEB2604	WRP REIMBURSEMENT	- 113,870.87
NAT11FEB2604	WRP REIMBURSEMENT	- 3,274.00
NAT11FEB2604	WRP REIMBURSEMENT	- 11,923.00
NAT11FEB2604	WRP REIMBURSEMENT	- 3,428.00
NAT11FEB2604	WRP REIMBURSEMENT	- 3,874.00
NAT11FEB2604	WRP REIMBURSEMENT	- 22,000.00
NAT11FEB2604	WRP REIMBURSEMENT	- 5,000.00
NAT11FEB2604	WRP REIMBURSEMENT	- 975.00
NAT11FEB2604	WRP REIMBURSEMENT	- 2,800.00
NAT11FEB2604	WRP REIMBURSEMENT	- 6,569.00
1374121626	GENERAL DAMAGES SETTLEMENT	4,000.00
1385622401	CRU	806.00
1374120467	CLAIMANTS SOLICITORS FEES	1,048.80
1376347188	GENERAL DAMAGES SETTLEMENT	10,000.00
1374122353	GENERAL DAMAGES SETTLEMENT	400.00
Totals		**- 499,983.73**

Welsh Ambulance Services University NHS Trust
Mar-26

Case Reference	Details	Amount (£)
1389612288	COUNSEL FEES	875.00
1395622093	DEFENCE COSTS	3,234.00
1397100971	DEFENCE COSTS	525.00
1398187424	DEFENCE COSTS	1,440.00
1389046372	DAMAGE TO VECHICLE	1,756.34
1390697471	DAMAGE TO VECHICLE	858.88
1392371044	PROFESSIONAL FEES	1,250.00
1393379935	PROFESSIONAL FEES	1,750.00
1393457759	DAMAGE TO VECHICLE	841.30
1395124713	TRANSCRIPTION SERVICES	41.21
1395123931	DAMAGE TO VECHICLE	5,320.83
1395126710	DAMAGE TO VECHICLE	950.59
1395123440	PROFESSIONAL FEES	30.00
1398187941	DAMAGE TO VECHICLE	1,142.40
1398306537	DAMAGE TO VECHICLE	1,660.56
1398860657	PROFESSIONAL FEES	15,400.00
1398803991	DAMAGE TO VECHICLE	1,067.72
1399465626	DAMAGE TO VECHICLE	887.42
NAT23MAR2604	WRP REIMBURSEMENT	- 24,928.50
NAT23MAR2604	WRP REIMBURSEMENT	- 13,106.00
1393458720	General Damages Settlement	12,000.00
1393460364	CLAIMANTS SOLICITORS FEES	10,580.00
1392373789	CLAIMANTS SOLICITORS FEES	6,714.60
1396606209	CRU	788.00
1395620267	GENERAL DAMAGES SETTLEMENT	7,500.00
1393378034	PROFESSIONAL FEE	50.00
1389613254	PROFESSIONAL FEE	2,200.00
1395125624	REDRESS PAYMENT	100.00
1400121381	COUNSEL FEES	525.00
1399987805	DAMAGE TO PROPERTY	4,400.23
BARCLAYCARD	COURT FEES	123.00
BARCLAYCARD	COURT FEES	123.00
Totals		**46,100.58**

Welsh Ambulance Services University NHS Trust
Losses and Special Payments

Annex 2

Summary of payments for the two months to 31st May 2026

	£
April 2026	£85,206.41
May 2026	£93,637.62
June 2026	£0.00
July 2026	£0.00
August 2026	£0.00
September 2026	£0.00
October 2026	£0.00
November 2026	£0.00
December 2026	£0.00
January 2027	£0.00
February 2027	£0.00
March 2027	£0.00
	£178,844.03

Losses and Special Payments Breakdown:

Payment Type	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£	£	£	£	£	£	£	£	£	£	£	£	
Claimants Solicitor Costs	12,902.39	56,703.80											69,606.19
Counsel fees	1,847.50	3,563.50											5,411.00
CRU	2,338.00	0.00											2,338.00
Damages	9,578.24	2,500.00											12,078.24
Defence Costs	26,244.63	5,731.52											31,976.15
Expert Witness	11,217.71	0.00											11,217.71
Vehicle Repairs	18,602.94	24,490.80											43,093.74
WRP Refund	2,475.00	0.00											2,475.00
Property Repairs	0.00	648.00											648.00
Court Refund													0.00
Total	**£85,206.41**	**£93,637.62**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£178,844.03**

22RT4PI0006

Welsh Ambulance Services University NHS Trust	Key	
Losses and Special Payments	MN	Medical Negligence
	PI	Personal Injury
Summary of payments for the twelve months to 31st March 2026	DP	Damage To Property
	£	
DP cases < £1,000	3,600.15	11 Cases
Redress cases < £1000		
PI cases < £1000	2,146.00	3 Cases
25RT4MN0019	30,500.00	
24RT4PI0033	24,500.00	
27RT4DP0009	12,136.39	
27RT4DP0002	9,654.68	
27RT4EG0004	9,000.00	
27RT4DP0019	8,317.72	
24RT4PI0058	4,703.80	
27RT4GN0001	4,500.00	
27RT4DP0001	3,998.63	
27RT4DP0008	3,877.42	
27RT4DP0016	3,822.16	
27RT4DP0018	3,349.02	
27RT4DP0011	3,332.10	
27RT4DP0021	3,300.00	
26RT4DP0114	3,100.26	
26RT4MN0015	3,045.00	
27RT4DP0006	3,042.64	
27RT4EG0002	2,730.00	
27RT4DP0020	2,614.30	
24RT4GN0022	2,475.00	
23RT4MN0014	2,468.50	
27RT4DP0007	2,439.92	
27RT4DP0010	2,248.45	
27RT4EG0009	2,000.00	
26RT4PI0016	1,921.60	
24RT4PI0031	1,911.00	
27RT4DP0015	1,838.58	
24RT4MN0007	1,820.00	
24RT4MN0005	1,750.00	
27RT4DP0004	1,649.35	
26RT4EG0035	1,500.00	
27RT4EG0003	1,500.00	
25RT4MN0027	1,375.00	
26RT4DP0117	1,308.86	
27RT4EG0008	1,295.00	
26RT4EG0024	1,250.00	
26RT4DP0055	1,200.00	
26RT4GN0014	1,000.00	
25RT4MN0020	472.50	
25RT4MN0016	150.00	
Total	**178,844.03**	

Welsh Ambulance Services University NHS Trust
Feb-26

Case Reference	Details	Amount (£)
1404731587	EXPERT WITNESS	1,050.00
1409928229	EXPERT WITNESS	1,050.00
1404499540	EXPERT WITNESS	1,820.00
1404724061	COUNSEL FEES	472.50
1409336099	COUNSEL FEES	1,375.00
1403980221	TRANSCRIPTION SERVICES	25.83
1403985109	TRANSCRIPTION SERVICES	5.78
1404034724	PROFESSIONAL FEES	2,730.00
1409335073	DAMAGE TO VEHICLE	3,420.29
1409331521	DAMAGE TO VEHICLE	578.34
1409332228	DAMAGE TO VEHICLE	9,654.68
1408317591	DAMAGE TO VEHICLE	1,308.86
1411580946	DAMAGE TO VEHICLE	690.00
1409335627	PROFESSIONAL FEES	1,500.00
1409929890	DAMAGE TO VEHICLE	1,649.35
1411693069	DAMAGE TO VEHICLE	245.00
1411580198	DAMAGE TO VEHICLE	2,156.64
1411691396	DAMAGE TO VEHICLE	2,439.92
1411693705	DAMAGE TO VEHICLE	3,100.26
1412722722	DAMAGE TO VEHICLE	3,877.42
1413762932	DAMAGE TO VEHICLE	886.00
1413765262	DAMAGE TO VEHICLE	4,787.71
1414361863	DAMAGE TO VEHICLE	2,248.45
1414363510	DAMAGE TO VEHICLE	6,795.00
1416667555	DAMAGE TO VEHICLE	3,332.10
1417556687	PROFESSIONAL FEES	1,500.00
1418256766	DAMAGE TO VEHICLE	553.68
1418193655	PROFESSIONAL FEES	1,250.00
1418259593	PROFESSIONAL FEES	9,000.00
1403982212	CRU	766.00
1409924322	CLAIMANTS SOLICITORS FEES	1,911.00
1403983975	CRU	766.00
NAT27APR2604	OVERPAYMENT OF CLAIMANTS SOLICITORS FEE	- 192.00
1403983022	CRU	806.00
1409388907	GENERAL DAMAGES SETTLEMENT	1,073.80
1409923780	GENERAL DAMAGES SETTLEMENT	847.80
1404725187	CLAIMANTS SOLICITORS FEES	1,750.00
1417558487	GENRAL DAMAGES SETTLEMENT	1,000.00
1409931962	GENRAL DAMAGES SETTLEMENT	4,500.00

Welsh Ambulance Services University NHS Trust
Mar-26

Case Reference	Details	Amount (£)
1422820814	PROFESSIONAL FEES	500.00
1420898207	COUNSEL FEES	368.50
1422821773	COUNSEL FEES	150.00
1425483969	COUNSEL FEES	1,545.00
1428823668	COUNSEL FEES	1,500.00
1419313658	PROFESSIONAL FEES	760.00
1422093101	DAMAGE TO VEHICLE	49.02
1423697016	DAMAGE TO VEHICLE	1,838.58
1424401598	TRANSCRIPTION COSTS	254.32
1424402178	TRANSCRIPTION COSTS	143.50
1424401156	TRANSCRIPTION COSTS	28.70
1425483472	DAMAGE TO VEHICLE	3,822.16
1427123931	PROFESSIONAL FEES	1,295.00
1424401156	PROFESSIONAL FEES	2,000.00
1423696436	PROFESSIONAL FEES	750.00
1427616966	DAMAGE TO PROPERTY	648.00
1428825124	DAMAGE TO VEHICLE	49.02
1429309787	DAMAGE TO VEHICLE	3,300.00
1429466940	DAMAGE TO VEHICLE	8,317.72
1430839569	DAMAGE TO VEHICLE	2,614.30
1430840778	DAMAGE TO VEHICLE	1,200.00
1431497196	DAMAGE TO VEHICLE	3,300.00
1424404285	CLAIMANTS SOLICITORS FEES	24,000.00
1425425992	GENERAL DAMAGES SETTLEMENT	2,500.00
1425425992	CLAIMANTS SOLICITORS FEES	2,203.80
1422094990	CLAIMANTS SOLICITORS FEES	30,500.00
Totals		**93,637.62**

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

Agenda Item No.	12

REPORT TITLE

Integrated Governance Framework

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	23 June 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Trish Mills, Director of Corporate Governance/Board Secretary

PURPOSE OF REPORT

☐ Approval	☒ Endorsement
☐ Assurance	☐ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY:

[See writing and presentation guidance here to inform this section]

1. This paper provides an update on the development of the Trust's integrated governance framework, a programme that has been overseen by this committee since March 2025.

2. The paper marks a key point in the programme, bringing together multiple strands of work to provide, for the first time, a single, coherent articulation of how accountability, governance and assurance operates across the organisation. It reflects progress made

alongside wider system developments, including the NHS Wales operating and accountability framework, internal structural changes to delivery groups, and external feedback from the Good Governance Institute (GGI).

3. The attached framework overview (**annex 1**) sets out the "floor to board" model, describing how accountability flows from Welsh Government through the chair and chief executive, and how governance structures (board, committees, executive leadership team and delivery groups) operate as an integrated system. It also explains how assurance is generated and triangulated through the three lines of defence model and consolidated at board level through the Board Assurance Framework.

4. The framework remains at an early stage of maturity, with this representing an initial consolidation rather than a fully embedded system. A programme of further work is required, including responding to the GGI review, progressing committee streamlining, refreshing board and committee agendas, and continuing development of delivery group structures.

5. There is recognised organisational risk around capacity and pace, given the scale and of change required. Moving from "good to great" in integrated governance is likely to take 2–3 years and attempting to accelerate this significantly may impact the sustainability and effectiveness of delivery.

6. This committee is requested to continue to monitor the programme in its role of providing assurance to the board on systems of internal control and governance.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The committee is requested to:

1. Endorse the integrated governance overview and, subject to any further adjustments, disseminate it more widely; and
2. Note progress to date and next steps and that a further update will be provided in January 2027 to allow some time for the delivery group work to progress.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

The committee is requested to receive the Integrated Governance Framework Overview **at annex 1.**

Governance and assurance checks to support decision-making and demonstrate alignment and risk mitigation

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☐ SO1: Providing the right care or advice, in the right place, every time	☐ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☐ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
No specific risk on the BAF to which this relates

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☐ Safe	☐ Timely	☐ Effective
☐ Efficient	☐ Equitable	☐ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☐ Leadership	☐ Workforce	☐ Culture
☐ Information	☐ Learning Improvement and Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☐ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☐ A pro-active, accessible and equitable care provider
☒ n/a	☐ n/a	☒ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document here for further details.

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
12 June 2026	Circulation to executive leadership team
2 September 2025	ARAC agreed outline of annex 1

SITUATION

1. This paper provides an overview of WAST's evolving integrated governance framework and seeks to update the committee on progress in strengthening that framework.

2. This committee has been monitoring the delivery of the integrated governance programme since its formal introduction in March 2025. This paper represents a key point in that programme, bringing together a number of developments to provide a clearer articulation of how governance, accountability and assurance operate across the organisation.

BACKGROUND

3. Since March 2025, the Trust has been progressing a programme of work to develop and embed an integrated approach to governance. At the outset, this committee:

    - received mapping of the Trust's governance frameworks, from board through to internal governance structures
    - approved underpinning principles to guide the development of the integrated governance approach

4. Between March 2025 and March 2026, the committee has received regular updates on the development of supporting materials and tools and the overall progress of the programme.

5. This work has taken place alongside a number of important contextual developments, including:

    - the introduction from 1 April 2026 of the NHS Wales operating and accountability framework, which provides clearer expectations on system and organisational accountability
    - the desire to refresh and strengthen delivery group structures
    - independent feedback from the Good Governance Institute (GGI) on board effectiveness and opportunities to move from "good to great" in integrated governance

6. The combination of these factors has enabled the Trust to move towards a more coherent and clearly articulated integrated governance framework.

ASSESSMENT

Integrated Governance Overview

7. Attached at annex 1 is the first version of the Trust's integrated governance framework document. Whilst various elements of the framework are expressed elsewhere, this is the first coming together of the floor to board approach.

8. This document sets out how accountability, governance and assurance operate across the organisation to support effective stewardship, delivery and control within the NHS Wales system.

9. **Accountability** for the Trust originates with Welsh Government and flows through the chair and chief executive. This is discharged through aligned objectives, delegated authority and structured governance arrangements.

10. Within a complex system of national policy, commissioning and oversight, the integrated governance framework provides clarity and alignment, enabling the organisation to demonstrate how it meets its responsibilities to stakeholders, including patients, the public and Welsh Government.

11. The Trust's **governance framework** brings together four core key components:

    - The board, which sets strategic direction and provides independent oversight
    - committees, which undertake detailed scrutiny and provide assurance within defined remits
    - the executive leadership team, led by the chief executive as accountable officer, which coordinates delivery and oversight
    - delivery group structures, which support operational delivery and the generation of assurance

12. Together, these elements form a connected system through which strategic direction is translated into delivery and performance is monitored and controlled.

13. **Assurance** is the means by which the board gains confidence that the organisation is delivering its objectives, managing its risks and discharging its responsibilities. This is achieved through a structured flow of information and evidence from operational delivery through to board level, supported by triangulation and independent scrutiny.

14. The three lines of defence model explains how assurance is generated:

    - first line through operational delivery and management control
    - second line through oversight and coordination
    - third line through independent assurance

15. The Board Assurance Framework (BAF) brings this together at board level, linking strategic objectives with principal risks, controls and sources of assurance. It enables the board to test whether risks are well understood, controls are effective and assurance is sufficient and reliable.

16. The framework is supported by a **suite of tools, guidance and templates** that enable consistent application across the organisation. These materials will continue to evolve as governance arrangements mature and organisational learning is applied.

17. This document is intended to provide an increased clarity and line of sight from national direction through to operational delivery and back to board-level assurance.

18. This committee is requested to endorse the framework overview for further dissemination to the board and the organisation.

What is next for the Integrated Governance Programme?

19. Further work is planned to continue strengthening the framework, including:

    (a) Consideration of the outputs of the GGI review. Initial outcomes were shared with the board at a development session in April, with the full report before the board in July.

    (b) Subject to the outputs from GGI, progress the recommendations to the board from ARAC regarding committee streamlining. This will include related work on skills mix of committee members.

    (c) Refresh of board and committee agendas and approaches (with further detail to be explored at the Board development session on 25 June).

    (d) Ongoing work of the Delivery Group Task and Finish Team (established by the executive leadership team and chaired by the Director of Corporate Governance), which will report back to ARAC in January 2027.

20. The above represents a considerable amount of work over a yet to be determined period of time. The pace of change and resource requirement will be one of the early pieces of work for the Delivery Group Task and Finish Team. It is likely that fully embedding change to go from good to great as a board and organisation will take 2-3 years and there is some nervousness regarding the organisation's capacity to deliver the full programme at pace that significantly truncates that.

RECOMMENDATION

21. The recommendation(s) are as set out in the front cover above.

NEXT STEPS

22. As set out above.

Integrated Governance Framework: An Overview

PURPOSE AND CONTEXT

This document provides an overview of the Trust's integrated governance framework, setting out how accountability, governance and assurance operate across the organisation. It explains how the Trust is directed, overseen and held to account, and how it demonstrates effective stewardship, delivery and control within the wider NHS Wales system.

The document brings together the key components of the governance framework, including accountability arrangements, governance structures, and risk and assurance processes. In doing so, it establishes a clear line of sight from national direction through to organisational delivery and back through assurance.

It is intended as a reference point for understanding how the organisation functions as a whole, rather than a detailed operating manual. It is supported by a suite of tools, guidance and templates, which provide practical application and will continue to evolve as the framework matures.

The document is structured in four parts:

Part 1: **Accountability** – the external and internal accountabilities that shape the Trust's role and responsibilities

Part 2: **Governance frameworks** – how the organisation is structured to discharge those responsibilities

Part 3: **Assurance** – how the organisation gains and provides confidence in its delivery, risk management and control

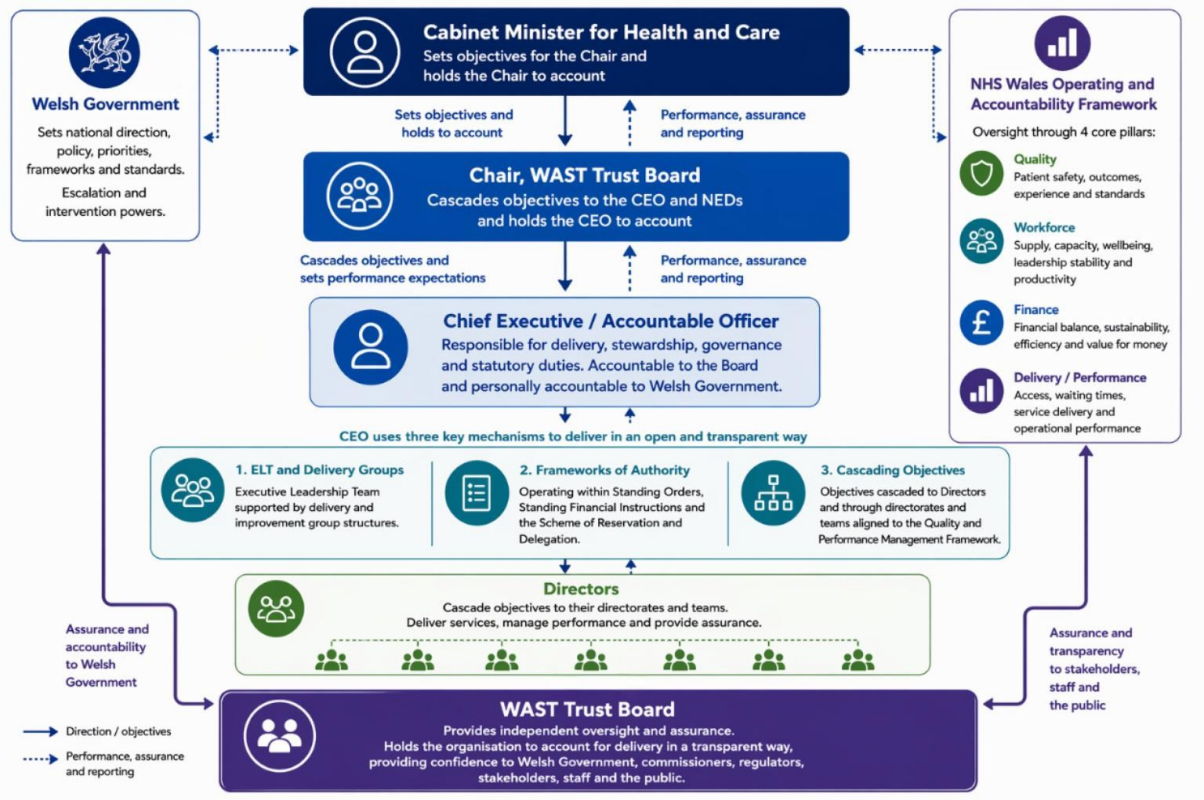
Part 4: **Supporting tools and guidance** – the materials that support consistent and effective application of the framework

PART 1: ACCOUNTABILITY

At its core, an integrated governance framework exists to enable the Trust to discharge its accountability responsibilities in a clear and transparent way. It brings together the mechanisms through which expectations are set, performance is managed, and assurance is generated, ensuring that the organisation can demonstrate how it is meeting the requirements of its stakeholders. In doing so, it provides a coherent structure that connects national direction with local delivery and organisational accountability.

This accountability framework is illustrated below. At its simplest, Welsh Ministers hold ultimate accountability for NHS services, exercised through policy, direction and performance oversight. Accountability flows from Welsh Government to the Trust chair and chief executive, and is discharged through aligned objectives, delegated authority and an integrated governance framework that enables the board to demonstrate effective stewardship, delivery and control.

This illustrates the flow of accountability, objectives and assurance through the organisation:



Welsh Government

Health is devolved in Wales, and Welsh Ministers hold ultimate accountability for NHS services. This accountability is exercised through a number of routes including:

- Welsh Government setting national policy direction and planning requirements, including frameworks, priorities and strategies to which WAST must align, alongside performance standards introduced through national initiatives
- Ministers may issue directions and guidance to NHS bodies on how they exercise their functions

The Cabinet Minister for Health and Care is the senior minister responsible for health. The chair of the WAST Trust Board is accountable to the Cabinet Minister and receives annual objectives from them.

Welsh Government retains statutory accountability and intervention powers over NHS bodies, including determining their escalation status. Oversight is exercised through the NHS Wales operating and accountability framework, which is structured around four core pillars providing a balanced view of organisational and system performance:

- **quality** – patient safety, clinical outcomes, experience and compliance with standards
- **workforce** – supply, capacity, wellbeing, leadership stability and productivity
- **finance** – financial balance, sustainability, efficiency and value for money
- **delivery/performance** – access, waiting times, service delivery and operational performance

A leadership and governance domain underpins all four pillars, with a focus on board effectiveness, executive leadership, organisational culture and grip.

The framework is supported by formal performance and accountability mechanisms, including the integrated quality and performance dashboard (IQPD) and public accountability meetings, alongside regular engagement with national leaders.

The Cabinet Secretary is supported by the Director General for Health and Social Care, who also serves as Chief Executive of NHS Wales Performance and Improvement, and is responsible for overseeing NHS delivery and performance across Wales.

Welsh Government meet biannually with Audit Wales and Healthcare Inspectorate Wales to review each health body's escalation status. From April 2026 that will be based on the NHS Wales operating and accountability framework, as well as outcomes from structured assessment and regulatory inspection outcomes.

The Trust

The chair cascades their objectives to the chief executive and non-executive directors. Quarterly performance discussions are held with the chief executive and annual appraisal are held with non-executive directors.

In addition to aligned objectives, the chief executive is responsible for delivering the organisation's commissioning intentions, meeting the requirements of the NHS Wales operating and accountability framework, and fulfilling their role as accountable officer.

As accountable officer, the chief executive is personally accountable to Welsh Government for the stewardship, governance and performance of the Trust, including meeting statutory duties, while remaining accountable to the board for delivery of its strategy and decisions.

To discharge these responsibilities in an open and transparent way, the chief executive relies on three key mechanisms:

- establishing an executive leadership team, supported by delivery and improvement group structures
- operating within a clear framework of delegated authority set out in standing orders, standing financial instructions and the scheme of reservation and delegation – all of which are board approved
- cascading objectives through directors and their teams, aligned to the WAST quality and performance management framework

The Trust Board is established under standing orders issued by Welsh Government to ensure the organisation is structured to meet its statutory duties and strategic objectives. It holds the organisation to account for delivery in a transparent manner, providing confidence to Welsh Government, commissioners and the public that the Trust is operating effectively, with appropriate oversight, control and assurance in place.

Annually our external auditors, Audit Wales, conduct a core structured assessment to provide an objective view on the board's effectiveness. The board and its committee also review their effectiveness annually through a robust quality governance review process overseen by the Audit, Risk and Assurance Committee.

The Wider System

WAST, as a statutory NHS Trust, retains sovereignty over its decision making through its board and internal governance framework, determining how it delivers its functions. This is however exercised within a wider system where Welsh Government policy, commissioning arrangements via the Joint Commissioning Committee, and external oversight shape funding, expectations and performance.

Because of this, there are a number of other ways in which WAST's strategic direction and operational decisions are influenced and shaped, and they come with additional accountability responsibilities.

Ensuring alignment of all initiatives, frameworks, policies, and statutory provisions can be challenging in a complex system such as health.

Other stakeholders of accountability importance include:

- **The Joint Commissioning Committee**

  The JCC was established on 1 April 2024 as a statutory joint committee of the seven health boards, combining and replacing previous all-Wales commissioning arrangements. It is not a sovereign NHS body and is hosted by Cwm Taf Morgannwg University Health Board (CTMUHB).

  For WAST, commissioning is pan-Wales and expressed through commissioning intentions for ambulance services and NHS 111 Wales, including performance and clinical outcomes. Funding is provided by health boards in proportion to population.

  The IMTP is the vehicle through which commissioning intentions are delivered. The funding received is to deliver targets and outcomes, and WAST determines how to organise itself to achieve those outcomes.

- **NHS Wales Performance and Improvement**

  NHS Performance and Improvement act as the single operational assurance interface with each organisation, consolidating intelligence across the four pillars of quality, workforce, finance, delivery/performance and the domain of leadership/well-led. They provide structure, escalation-matched support and monthly system synthesis to Welsh Government. They are not a statutory body, and are hosted by Public Health Wales.

  The Chief Executive of NHS Wales Performance and Improvement is accountable to the Cabinet Minister for the oversight and performance of NHS Wales, and responsible for providing policy advice and exercising strategic leadership and management of the NHS Wales.

- **Other NHS Bodies in Wales**

  The organisational and governmental structure of the NHS in Wales is primarily set out in the National Health Service (Wales) Act 2006.

  There are three principal kinds of NHS bodies under the 2006 act:

  Local Health Boards

  - Aneurin Bevan University Health Board

- Betsi Cadwaladr University Health Board
- Cardiff and Vale University Health Board
- Cwm Taf Morgannwg University Health Board
- Hywel Dda University Health Board
- Powys Teaching University Health Board
- Swansea Bay University Health Board

NHS Trusts Special

- Public Health Wales
- Velindre University NHS Trust
- Welsh Ambulance Services University NHS Trust

Special Health Authorities

- Digital Health and Care Wales
- Health Education and Improvement Wales

From time to time WAST will enter into agreements with health boards for delivery of services outside of the commissioning arrangements and will have performance objectives and relationship management responsibilities for those agreements.

- **NHS Wales Shared Services Partnership (NWSSP)**

  NWSSP delivers a range of professional, technical and administrative services on behalf of all health bodies, including internal audit, payroll, procurement and legal services.

  As with health boards, there will be various performance measures – both with respect to NWSSP services to us and our engagement with them – where the organisations hold each other to account.

Across this landscape, accountability is exercised through a wide range of interconnected policy frameworks, statutory provisions, commissioning arrangements and oversight mechanisms set at national level. While each serves a distinct purpose, they are underpinned by common principles relating to quality, performance, stewardship, transparency and control.

For the Trust, the challenge and the opportunity is in aligning these requirements into a coherent whole, identifying the common denominators that enable clear accountability flows from national direction through to local delivery and back through assurance. This is inherently complex within a multi organisational system, and it is this complexity that an integrated governance framework is designed to simplify, bringing clarity, consistency and line of sight to how accountability is discharged across the organisation.

In summary:

- accountability flows from Welsh Government through the chair and chief executive, enabled by clear objectives, delegated authority and governance arrangements
- the integrated governance framework connects national direction, organisational delivery and board oversight into a single, coherent system
- the chief executive, as accountable officer, ensures delivery, stewardship and governance through the executive leadership team, delegated frameworks and cascaded objectives
- the board provides independent oversight, holding the organisation to account and ensuring transparency, assurance and control
- in a complex system, the framework brings clarity and alignment, enabling accountability from national direction through to local delivery and back through assurance

PART 2: OUR GOVERNANCE FRAMEWORKS

Whilst effective governance depends on strong mechanics and dynamics, clear and proportionate structures remain fundamental to discharging accountability. The Trust's governance framework is designed to provide robust oversight, decision making and assurance in line with its accountability obligations. At a summary level, the core components of that framework at WAST comprise:

- Trust Board
- Board committees
- Executive Leadership Team
- Delivery group structures

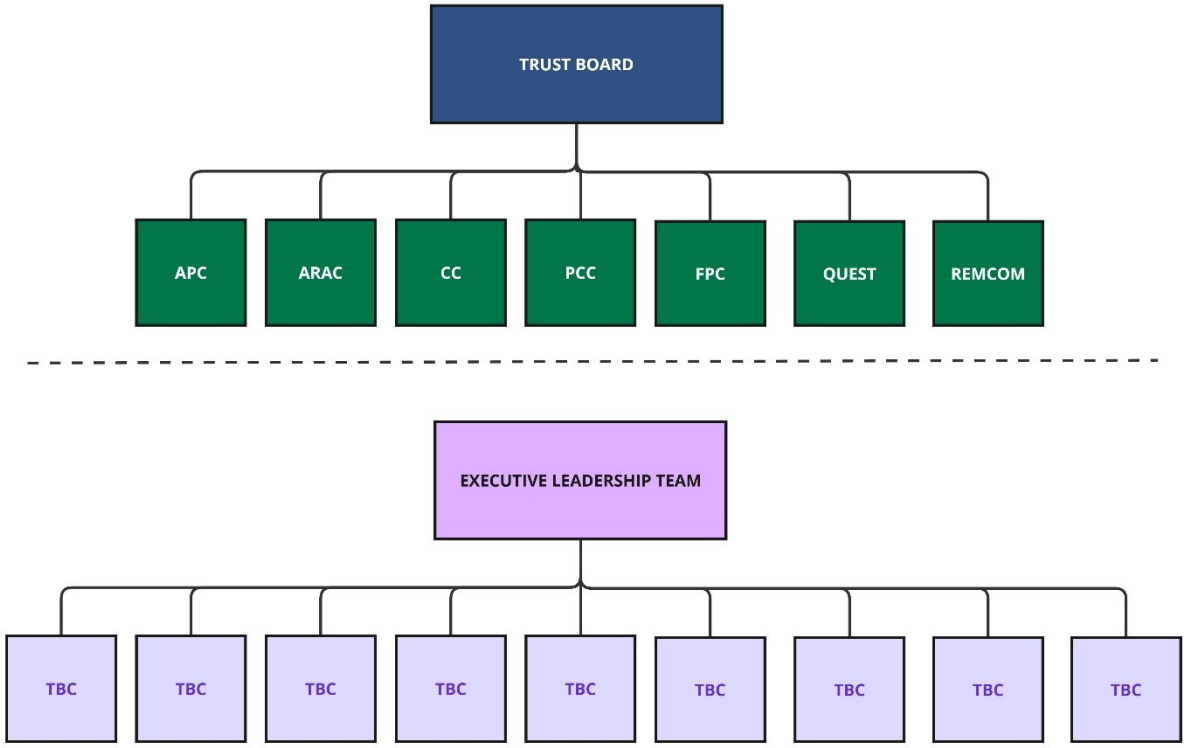
Together, these form a distinct but interconnected system through which accountability is exercised, from strategic direction and oversight at board level through to operational delivery and assurance.

Following the Good Governance Institute review in 2026, there is a clear ambition to further strengthen these arrangements at all levels. The executive leadership team has recently revised its terms of reference to more explicitly aligned to the NHS Wales operating and accountability framework and the responsibilities of the accountable officer. The next phase of this work is focused on the internal governance structures – or delivery groups - that report into the executive leadership team. Existing structures have developed organically over time and now require greater clarity, consistency and alignment.

This delivery group review commenced in 2026. The oversight of this work by the Audit, Risk and Assurance Committee will be key to provide assurance and confidence to the board in the robustness of the integrated governance framework as a whole, rather than disparate parts.

Given the evolving nature of this work, this document does not set out a detailed description of current internal forums, which are expected to change. Instead, it focuses on the enduring elements of the framework, namely the board, its committees and the executive leadership team, recognising that the structures beneath these are under active development to ensure they are fit for purpose within an integrated governance model.

This shows the structural components through which governance is exercised.



Refresh Underway

Trust Board

The trust's standing orders are drawn from legislative provisions, primarily from the NHS Act, but also incorporate standard corporate governance code principles. This document as well as our standing financial instructions and scheme of reservation and delegation drive the work of the board and are complemented by individual terms of reference for each board committee.

The board's primary role is to:

- develop strategy (i.e. the 'North Star' for the organisation)
- hold the executive to account for delivery of the strategy and agreed desired outcomes
- ensure risks to strategic delivery are known and managed within set risk appetites
- set and model the culture of the organisation

In doing so it ensures the Trust has the right strategy, aligned to Welsh Government and system priorities, that it has the right resources to deliver the strategy, and that it has the right governance to do so i.e. the mechanics (structures and flows and roles/responsibilities) and dynamics (behaviours, consistency, effectiveness).

Annually our structured assessment from Audit Wales reviews this and provides an external and independent view to the board upon which it can assess the effectiveness.

The board is comprised of independent members and executive members, ensuring that there is objectivity, appropriate challenge, scrutiny, transparency and support. Independent members are appointed by Welsh Government, and as set out above, the chair is held accountable for the performance of the Trust by the Cabinet Minister.

The board also acts as the corporate trustee of the WAST charity.

Board Committees

Whilst standing orders for Trusts and Health Boards are standard in Wales, we are afforded a degree of flexibility in how we establish our committee structures and the ways in which we provide assurance to them and onward to the board. It is partly for this reason that we undergo stringent annual effectiveness reviews to ensure that those committees and the board are operating effectively.

Our WAST committees include:

- **Academic Partnerships Committee**, whose purpose is oversight of the Trust's research governance framework.

- **Audit, Risk and Assurance Committee**, whose purpose is to advise and assure the board and accountable officer that the Trust's system of assurance and internal control is effectively designed and operating to support sound decision making and the delivery of organisational objectives, in line with NHS Wales governance standards. It also identifies opportunities to strengthen and develop the assurance system where needed.

- **Charity Committee**, whose purpose is to support the development and delivery of the charity's strategy while assuring the Corporate Trustee that charitable funds are properly managed, used and invested in line with legal and public benefit requirements.

- **Finance and Performance Committee**, whose purpose is to provide scrutiny and oversight of the Trust's financial performance, statutory duties and delivery of its core objectives, including progress against the IMTP and agreed targets. It reviews the robustness of cost improvement plans, strategic delivery and long term value, and scrutinises business cases for investment. It also oversees key enabling strategies, including digital, estates, fleet and environmental plans, alongside business continuity, resilience, information governance and cyber security.

- **People and Culture Committee**, whose purpose is to provide scrutiny of the Trust's workforce and organisational culture, covering both paid staff and volunteers, and assure the board on leadership, culture and behaviours, workforce development, equality and inclusion, health and wellbeing, partnerships and engagement, including WAST partnership arrangements, and compliance with Welsh language and regulatory standards.

- **Quality, Patient Experience and Safety Committee**, whose purpose is to scrutinise improvements in outcomes in quality, patient experience, effectiveness, and safety to reduce incidences of avoidable harm. It provides oversight of and seeks assurance on statutory and regulatory compliance, including but not limited to the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

- **Remuneration Committee** whose purpose is to exercise delegated authority on behalf of the board for senior appointments, remuneration, terms of service, appraisal and termination arrangements, ensuring compliance with Welsh Government frameworks and Standing Orders. It also provides assurance that remuneration and contractual arrangements for all staff are appropriate and aligned with NHS Wales standards, with proper scrutiny of any termination payments.

Whilst they all have different remits, their primary role is to:

- ensure annually that actions for strategic objectives in its remit are appropriately paced, stretching and resourced - preferably before they are board approved
- monitor delivery of strategic objectives in their remit, the risks to those objectives, and that the proposed outcomes are being realised; ensuring improvement plans are in place and effective where appropriate

- operate to effectively discharge other areas of its terms of reference, particularly as they relate to statutory responsibilities, applied learning, resilience, etc
- report to the board in a timely way on its work, escalating issues where necessary

The Trust also has on advisory board which is the **Welsh Ambulance Service Partnership Team (WASPT)**, which is the primary strategic local partnership forum. Membership consists of members of the executive leadership team and three members of each of the four recognised trade unions. WASPT reports into the People and Culture Committee.

Executive Leadership Team

The executive leadership team comprises the chief executive all directors. The team meets weekly in a mix of formal and information meeting structures and huddles.

The accountable officer establishes the executive leadership team to support in the discharge of their duties and to ensure oversight that the right things are being done by the right person at the right time.

The terms of reference for executive leadership team meetings are based on the NHS Wales Operating and Accountability Framework pillars of quality, workforce, finance, delivery/performance, and the domain of leadership. At a minimum, its work programme centres around these, as well as the objectives of the chair and chief executive, and accountability conditions.

Delivery Groups

The Trust's delivery and improvement structures sit at an operational level, with the executive leadership team operating as the principal executive forum. A number of established groups currently support the executive leadership team in discharging its responsibilities, spanning areas such as quality, performance, governance, safety, transformation and enabling functions. These arrangements have developed over time to respond to organisational priorities and requirements, with further supporting groups in place to drive delivery and assurance at operational level.

As the organisation continues to evolve, there is an opportunity to bring greater clarity and consistency to how these forums operate collectively. In particular, this includes strengthening alignment between the executive leadership team, its supporting groups and board committees, and ensuring that routes for decision making, escalation and assurance are clear, proportionate and consistently applied. This will support a more streamlined flow of information, enabling executive leadership team to focus on its core role while maintaining clear oversight of delivery and risk.

The programme of work – key to unlocking a true integrated governance programme - commenced in 2026 and will be overseen by the executive leadership team and the Audit, Risk and Assurance Committee.

In summary:

- the integrated governance framework brings together the board, committees, executive leadership team and delivery groups into a single, connected system of oversight, decision making and assurance
- the board sets direction and provides independent oversight, holding the executive to account for delivery, performance and risk
- committees provide focused scrutiny and assurance within their remit, strengthening board oversight
- the executive leadership team, led by the chief executive/accountable officer, coordinates delivery and ensures alignment to national and organisational priorities
- delivery groups enable operational delivery and assurance, with ongoing work to strengthen alignment, consistency and clarity across the framework

PART 3: ASSURANCE

As set out in the preceding sections, direction flows from Welsh Government through the chair and chief executive, with objectives cascaded throughout the organisation. In parallel, assurance flows back up through the organisation to demonstrate that those objectives are being delivered, risks are being managed and statutory responsibilities are being met.

An effective assurance framework therefore provides a clear line of sight from frontline delivery (whether that be operational or corporate) through to board and stakeholder oversight. It enables the organisation to demonstrate that it is operating effectively and in accordance with the requirements set by its stakeholders.

What is Assurance?

Assurance is the process by which the organisation, the board and our stakeholders gain sufficient, evidence based confidence that the Trust is delivering its objectives, managing its risks and discharging its responsibilities.

It provides the mechanism through which the organisation can demonstrate that direction, set externally and internally, is being translated into effective delivery.

Assurance does not provide absolute certainty. The board must instead be satisfied that reasonable assurance exists, based on triangulated evidence drawn from a range of internal and external sources.

A robust assurance approach supports the board to make informed decisions and judgements and discharge its accountability duties effectively. This includes ensuring that:

- risks are identified, assessed and actively managed
- controls are defined, implemented and reviewed for effectiveness
- high quality data supports decision making
- issues are escalated appropriately in line with delegation arrangements
- evidence is available to demonstrate delivery, compliance and improvement

Triangulation

Triangulation is key to effective assurance. It involves testing information across multiple sources and types of evidence to build a consistent and reliable picture of performance and risk.

This might include:

- using timely performance and risk information to monitor delivery
- looking beyond reports to understand the lived experience of staff, patients and communities
- testing information through multiple sources and types of evidence
- seeking evidence of sustained improvement where action has been taken
- drawing on independent scrutiny and external insight
- maintaining constructive challenge from all board members
- supplementing formal reporting through board visits, engagement and observation

Triangulation enables the board to test whether the assurance being provided reflects organisational reality, strengthening confidence in the overall accountability framework.

Assurance Versus Reassurance

It is important to distinguish between assurance and reassurance.

- assurance is grounded in objective, triangulated evidence from multiple sources
- reassurance relies more heavily on narrative, judgement and management explanation

Examples might include:

- reassurance: "waiting times are improving"
- stronger reassurance: "we have reviewed the data and management have explained the improvement plan"
- assurance: "validated waiting time data, triangulated with operational reports and patient feedback, shows sustained improvement over three months, supported by internal audit review of the underlying controls"

Both are necessary. Effective governance requires a balance, ensuring that narrative is supported by evidence, whilst avoiding over reliance on either raw data or unchallenged management commentary.

In practice, boards should expect to move from reassurance to assurance, using questioning, triangulation and independent evidence to build a robust and reliable picture of organisational performance and risk.

Sources of Assurance

Assurance is derived from multiple sources across the organisation and its governance structures. The board's role is not only to receive assurance, but to assess its quality, sufficiency and independence, and to identify any gaps or duplication.

A helpful way to understand and structure assurance is through the three lines of defence model, which describes where assurance is generated and how it is strengthened.

First line, operational management and control

Assurance generated through day to day delivery:

- line management and delegation arrangements
- compliance with policies, procedures and frameworks
- performance and finance reporting
- incident reporting and thematic review
- risk management processes

- workforce processes such as PADRs

This is where assurance is created at source.

Second line, oversight and coordination

Assurance gained through oversight, monitoring and challenge within the organisation:

- quality and performance management framework
- delivery groups and internal governance structures
- key metrics and reporting frameworks
- audit tracking and follow up
- clinical audit and quality standards
- risk management functions and compliance activity
- organisational frameworks such as equality, Welsh language and governance codes

This strengthens and validates first line assurance.

Third line, independent and objective assurance

Assurance provided independently of management:

- internal audit
- Audit Wales and external audit
- Healthcare Inspectorate Wales inspections
- Welsh Government reviews and escalation status
- peer reviews
- stakeholder and public feedback, including Llais
- Ombudsman, Coroner and regulatory findings

This provides independent confidence in the effectiveness of governance, risk and control.

How to use the model in practice

The three lines of defence should not be seen as separate systems, but as a connected assurance chain.

In practice, this means:

- assurance should be generated at the point of delivery and supported through robust management control
- oversight functions should test, validate and challenge that assurance
- independent assurance should confirm whether systems are operating effectively

The board should seek to understand:

- whether all three lines are operating effectively
- where it is relying most heavily for assurance
- whether there are gaps, duplication or over reliance on a single source

Together, the three lines provide a clear flow of assurance from operational delivery through to board level oversight.

If assurance is everything, what is the Board Assurance Framework?

While assurance describes the overall system and flow of evidence and confidence, the Board Assurance Framework (BAF) is a specific tool used by the board to focus on what matters most.

The BAF brings together:

- the organisation's strategic objectives
- the principal risks to achieving those objectives
- the controls in place to manage those risks
- the sources of assurance that those controls are working

In this sense, the BAF answers a more focused question: "Are we confident that we will achieve our objectives, given the risks we face and the strength of our controls and assurance?"

The assurance framework describes how assurance is generated, strengthened and flows through the organisation, providing a comprehensive system of evidence and confidence from operational delivery through to board oversight.

The Board Assurance Framework, in contrast, draws on that wider assurance to present a structured, risk based view at board level. It brings together the organisation's strategic objectives, the principal risks to their delivery, the controls in place to manage those risks, and the sources of assurance that those controls are operating effectively.

In doing so, the BAF highlights where assurance is strong, where it is limited, and where there may be gaps in control or assurance. It supports informed board discussion, constructive challenge and decision making, ensuring that the board is not simply receiving information but is actively testing whether the right risks have been identified, whether controls are effective, and whether the assurance available is sufficient and reliable.

The BAF therefore provides the board with a focused lens on its most significant risks, drawing on the wider assurance framework to support informed judgement.

In summary:

- assurance is the system of confidence across the organisation
- the three lines of defence explain where that confidence comes from
- the BAF brings this together to show whether the board can rely on that confidence in delivering its objectives

PART 4: SUPPORTING TOOLS, GUIDANCE AND MATERIALS

This handbook is supported by a suite of tools, guidance and templates designed to enable the practical application of the integrated governance framework across the organisation. These materials provide clarity on roles, processes and expectations, and support consistent, high quality governance practice at all levels.

The suite is deliberately iterative. While a number of components are already in place, others will be developed as the framework matures and the delivery group work progresses. All materials will be subject to ongoing review, informed by user feedback, organisational learning and changes in the external environment.

The components include:

- **Corporate Governance Secretariat SOP**
  Already established for the board and its committees, operating through a Kanban approach with a streamlined version to be developed to support delivery groups.

- **Governance forum mapping**
  A baseline mapping of governance forums from frontline to board has been completed and reported to ARAC in March 2025 which will continue to evolve.
- **Writing templates and guidance**
  Templates and associated guidance for written and presentation materials are in use and being improved iteratively.
- **Meeting Guidance**
  This has been drafted and further detail related to recording of meetings and the information governance considerations for this are being finalised.
- **Minutes and AAA guidance**
  Guidance to support clear, outcome focused and assurance based recording and reporting, aligned to the AAA framework.
- **Use of artificial intelligence in governance**
  Guidance (some of which is included in existing documents above) on how to use AI to be more effective and efficient, whilst still maintaining core governance skills.
- **Roles and responsibilities guidance**
  Clarifying the expectations of chairs, secretaries, members and observers within governance forums.
- **Templates and standard documentation**
  A developing suite of templates to support consistent governance practice across the organisation.
- **Training and education**
  A structured offer to build capability in governance, assurance and effective scrutiny.
- **Legislative and regulatory universe**
  A consolidated view of statutory, regulatory and policy requirements to support alignment and compliance.

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	28 May 2026
Committee Meeting Date	28 April 2026
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS

ALERT (Alert the Board to areas of attention)

1. No issues for escalation to the board.

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

2. A **pre-meeting** was held with Audit Wales, Internal Audit and the committee Chair ahead of the meeting.
3. Members **reflected** positively on the quality of the papers and the depth and effectiveness of the discussion. It was noted that the meeting had concluded earlier than scheduled, which was welcomed. Reference was made to this being **Dr Umar Ahmad's first meeting**, and his contribution and engagement were welcomed. Overall, the meeting was regarded as productive and well-managed, reflecting a strong collective contribution from both members and officers.

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

2025/26 Committee Quality and Governance Reviews

1. All committees completed their reviews, with the exception of WASPT, which was deferred due to low survey response rates and will be concluded in June following improved engagement. All Committees approved their annual reports and only minor changes to terms of reference, with more substantive changes deferred pending the Good Governance Institute (GGI) review. The annual reports are **attached** to his AAA for review and approval by the board at their May meeting.

2. Across committees, the reviews did not identify material new governance concerns. Common themes included the need to reduce operational focus, strengthen strategic oversight aligned to organisational objectives, and ensure confidence in integrated governance and delivery arrangements below committee and Executive Leadership Team (ELT) level. Low survey response rates were noted as a recurring issue, with alternative approaches to be considered in future.

3. ARAC discussed committee attendance, including the use of deputies, and emphasised the importance of consistent attendance by members and officers to support effective assurance. While contextual factors such as interim roles, system pressures and diary clashes were acknowledged, ARAC agreed that maintaining consistency remains important. ARAC also discussed committee skills mix, noting increasing demands in specialist areas and emphasising the importance of understanding where skills gaps exist and how these are mitigated through the skills matrix, targeted development and access to appropriate expertise – work which the ARAC sub-group will undertake in 2026/27.

   Of note for the board for each of the committees:

   - Academic Partnership Committee was recognised as being in transition, having largely fulfilled its original purpose. Its sole current focus is research. While there remains an intention for research oversight to transfer to the Finance and Performance Committee, this has been deferred pending the GGI review. ARAC was assured that interim arrangements are appropriate.

   - Charity Committee was assessed as significantly strengthened over the past 12–18 months, with no requirement for major change. Ongoing development remains necessary, particularly around capacity to deliver and continued clarity on conflicts of interest and trustee roles. Overall effectiveness and proportionality were confirmed.

   - Finance and Performance Committee was considered effective, with strong foundations in place. Discussion highlighted increasing pressures arising from financial constraints, capacity limitations, and the breadth of its remit, including sustainability and estates. Structural issues were noted, including duplication with board business.

   - People and Culture Committee was assessed as operating well with key challenges including stepping away from operational detail, while maintaining assurance in higher-risk areas. Delivery groups below committee level were identified as a critical enabler for future effectiveness.

   - Quality, Patient Experience and Safety Committee was acknowledged as the most challenging committee due to system pressures and levels of harm. While reviewing positively, ARAC highlighted the risk of reducing operational details without sufficient confidence in underlying assurance arrangements. Meeting length, discipline of questioning, and officer attendance were discussed. Attendance variation was acknowledged as contextual, with agreement to reflect this explicitly in the AAA to Board.

   - Remuneration Committee arrangements were considered appropriate and effective, with short, focused meetings welcomed given overall non-executive workload. ARAC noted agreement to streamline Board business by no longer routinely including approved Committee minutes on the Board agenda, given existing assurance routes and public availability.

   - ARAC's own effectiveness review was positive. The Committee continues to use a rolling, continuous improvement approach based on the National Audit Office toolkit, achieving full engagement and meaningful scrutiny. Skills gaps were acknowledged, with assurance that these are being addressed through the skills matrix refresh and targeted development. ARAC discussed

the suboptimal sequencing of audit reports, noting that timing constraints sometimes prevent ARAC from being the first recipient. While no immediate solution was identified, the issue was formally noted and will be reflected in reporting to the Board.

4. **Audit Wales** updated the committee on progress and presented their audit plan for 2026. It was noted that the external audit of accounts is due to commence shortly following submission of the accounts on the 1 May. It was reported that performance audit work is progressing; however, the digital review of investment in digital systems was not available for this meeting due to internal delays. It will be shared reported to a future meeting alongside the Non-Emergency Patient Transport Services review. The deep dive review on arrangements to manage estates is currently in fieldwork and is expected to report later in the year. Members reviewed the **Audit Wales annual plan for 2026/27** and noted the anticipated audit fee for 2026/27 of £216,942, which is a 5.3% increase on the 2025/26 fee estimate.

5. **Internal Audit** reported steady progress against the 2025/26 plan noting there is confidence that the audit plan will be completed by June. The Internal Audit reviews that follow 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.

6. **Risk management and board assurance framework – Reasonable Assurance**. This audit assessed 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 committee took assurance from clear governance arrangements, regular review of principal risks by the board and committees, and improved articulation of risk appetite aligned to strategic objectives. The audit recognised positive developments, including greater movement in risk scores reflecting active mitigation, clearer differentiation between strategic and corporate risks, and progress towards a refreshed strategic board assurance framework (BAF). Members noted that the move to clearer strategic oversight linked to delivery of objectives and associated metrics.

   Two medium-priority findings related to updating references within the risk management policy and strengthening discipline around action management, particularly ensuring that completed actions translate into strengthened controls, updated assurance and, where appropriate, revised risk scores. ARAC agreed this represents the next stage of maturity rather than a fundamental weakness.

   Discussion also highlighted the highly manual nature of the current BAF process and the anticipated benefits of the planned in-house electronic risk management system. Members noted that implementation will be phased, with piloting planned, and that delivery timescales remain dependent on capacity. The committee will receive the high-level project plan on this in June.

   Overall, ARAC was assured that risk management arrangements are effective and moving in the right direction, while recognising that further work is required to embed a fully strategic BAF and strengthen the linkage between actions, controls and risk reduction.

7. **Welsh language standards – Reasonable Assurance**. This purpose of this audit was to provide assurance on the adequacy and effectiveness of the arrangements in place to comply with the requirements of the Welsh language standards.

   The audit recognised strong foundations, including clear executive leadership, established roles and responsibilities, a comprehensive Welsh Language Policy, and consistent statutory reporting, including timely publication of the Welsh Language Annual Report. The committee noted positive progress in embedding Welsh language considerations into service delivery, particularly through innovative approaches within NHS 111, and welcomed constructive engagement with the Welsh Language Commissioner's Office.

   Three medium-priority findings related to weaknesses in governance and monitoring arrangements, recording and escalation of Welsh language related complaints, and non-compliance with Standard 110 due to delays in assessing and publishing the required five-year plan.

   Members recognised were assured that actions are underway, including strengthening governance through alignment with People and Culture delivery groups, refreshing the Welsh language clinical consultation arrangements, and improving complaint recording processes. ARAC acknowledged that complaints volumes are low and that overall progress represents cultural improvement rather than narrow compliance.

   Overall, ARAC was assured that arrangements are improving and proportionate, with further work required to strengthen governance, consistency and assurance as part of wider organisational development. The People and Culture Committee will review this report at their May meeting.

8. **Capacity management plan (Ambulance Care) – Reasonable Assurance**. The purpose of this audit was to provide assurance that the capacity management plan (CMP) is being applied appropriately, with consistent decision-making and clear communication of outcomes to patients.

   ARAC recognised that the CMP is operating in an exceptionally pressured environment where demand routinely exceeds capacity. Strong operational foundations are in place, including clear guidance, training, scripts and dashboards. One high-priority finding related to the need for greater consistency, transparency and audit trail in decision-making, particularly around journey cancellations and prioritisation. Discussion highlighted the lack of objective thresholds, limited recording of rationale within systems, and the absence of systematic analysis of ineligible patients, appeals and downstream patient impact, compounded by eligibility criteria set nationally and not reviewed for many years.

   Members recognised the significant impact on patients and staff, including potential disproportionate effects, while taking assurance that management actions are appropriate and realistic, albeit dependent on system changes and funding. Overall, ARAC was assured that the CMP is functioning as intended within current constraints, with further work required to strengthen learning, assurance and patient impact visibility. The Finance and Performance Committee will review this audit at their May meeting.

9. **Job evaluation – Reasonable Assurance**. This audit assessed how effectively the requirements of the NHS Job Evaluation Handbook are being applied by the trust.

   ARAC noted a clear improvement from the previous limited assurance rating and welcomed progress made, including increased stability within the function, the absence of a backlog, and generally compliant processes for new roles, re-evaluations and reviews.

   Six medium-priority findings related to strengthening training records for job matchers and consistency checkers, improving documentation and audit trails, managing conflicts of interest, and enhancing performance reporting to the Executive Leadership Team. ARAC acknowledged the impact of recent capacity challenges and organisational change but took assurance that management actions are appropriate, timescales realistic, and that additional training is planned to support sustainability and staff confidence in the process.

   The People and Culture Committee will review this audit at their May meeting.

10. Register of interests and the gifts, hospitality and sponsorship registers were received with members welcoming the transparency of reporting of hospitality and the culture of declaration, while noting the relatively low volume of entries is consistent with sector benchmarks.

11. The annual governance statement in the Trust's annual report provides compliance with the 2017 corporate governance code for central government departments was and ARAC can assure the board that the self-assessment was reviewed, with no elements for escalation.

12. Governance practice notes, developed to aid interpretation of standing orders, were renewed. These related to the use of the Trust seal, division of business between private and public meetings, and the use of chair's actions.

RISKS

13. The risk management and board assurance audit was received as above.

COMMITTEE AGENDA		
2025/26 annual reports from committees	Internal Audit: - Progress report - Risk management and BAF audit - Welsh language standards audit - Capacity management plan audit - Job evaluation audit	Audit Wales update and 2026 audit plan
Register of interests, gifts and hospitality	Self-assessment against the 2017 corporate governance code for central government departments	Review of governance practice notes

COMMITTEE ATTENDANCE					
Name	**28 April 26**	**23 June 26**	**3 September 26**	**3 December 26**	**4 March 27**
Peter Curran					
Dr Umar Ahmed					
Ceri Jackson					
Julie Boalch					
Judith Bryce					
Christian Fox					
Wendy Herbert					
Fflur Jones					
Carl Kneeshaw					
Osian Lloyd					
Trish Mills					
Chris Turley					
Damon Turner					
Carl Window					

	Attended
	Deputy attended
	Apologies received
	No longer member

ALL WALES AUDIT COMMITTEE CHAIRS (AWACC) MEETING NOTES FROM THE MEETING HELD REMOTELY VIA MICROSOFT TEAMS ON 1 JUNE 2026 AT 11AM

Please note, this is not intended to serve as a formal minute of the meeting. It is a Copilot-generated summary designed to support those who were unable to attend and to inform the actions and decisions log.

It was agreed at the meeting held on 30 September that formal minutes would not be taken or presented in a public format. This decision reflects the nature of the All Wales Audit Chairs Committee, which is not a decision-making forum but rather a valuable peer support group.

MEMBERS PRESENT:

Peter Curran	Chair, Welsh Ambulance Services NHS University Trust
Anne Beegan	Audit Wales *(Part 1 only)*
Simon Cookson	NWSSP Internal Audit *(Part 1 only)*
Dave Edwards	Cardiff & Vale University Health Board, Independent Member
Rhodri Evans	Hywel Dda University Health Board, Independent Member
Michael Giannasi	Powys Teaching Health Board, Independent Member
Tom Haslam	Audit Wales *(Part 1 only)*
Gareth Jones	Velindre NHS Trust, Independent Member *(left at 11:55am)*
Iwan Jones	Aneurin Bevan University Health Board, Independent Member
Marian Jones	Digital Health Care Wales, Independent Member
Paul Lambert	Betsi Cadwaladr University Health Board Independent Member
Alun Lloyd	Health Education and Improvement Wales
Trish Mills	Director of Corporate Governance/Board Secretary, Welsh Ambulance Services NHS University Trust
Carl Window	Counter Fraud Manager, Welsh Ambulance Services NHS University Trust *(Part 1 only)*
Anthony Veale	Audit Wales *(left at 11:30am)*
Nuria Zolle	Swansea Bay University Health Board, Independent Member

IN ATTENDANCE:

Julie Boach	Assistant Director of Corporate Governance & Risk Welsh Ambulance Service NHS University Trust (*joined for Item 8.1)*
Sarah Harland	Secretariat, Welsh Ambulance Services NHS University Trust Welsh Ambulance Services NHS University Trust

APOLOGIES:

Pippa Britton	Chair of the Board, Public Health Wales
Stephen Elliot	Powys Teaching Health Board, Independent Member
Helen Jones	Audit Wales
Ceri Mcgaugie	Betsi Cadwaladr University Health Board, Corporate Office
Patsy Roseblade	Cwm Taf Morgannwg, Independent Member

PART A - EXTERNAL BRIEFINGS

Agenda Item 2 Action Log

- Trish Mills advised that the action relating to the development of a protocol to support Audit Committee members in managing multiple roles had been considered by the Directors of Corporate Governance, who concluded that existing Terms of Reference sufficiently address this issue. It was agreed that no separate protocol would be developed. The position was endorsed by the group, with no objections raised, and the action was therefore closed, noting that organisations may address the matter locally if required.

Agenda Item 3 Audit Wales Update

- Anne Beegan and Anthony Veale provided an Audit Wales update, outlining progress on a revised approach to structure assessments and forthcoming All-Wales summary reports on planned care and urgent and emergency care. It was noted that local digital audit work is largely complete, with consideration being given to producing a national summary of findings and undertaking further work on system-wide digital challenges. An update on year-end accounts confirmed work is progressing to timetable, with limited issues identified in relation to remuneration reporting, linked to the application of existing guidance.

- Members welcomed the update, particularly the focus on digital transformation, highlighting the complexity of the landscape and the importance of timely, consolidated national insights. Discussion emphasised the value of sharing all-Wales learning and improving visibility of interdependencies and shared risks across organisations. Clarification was sought on remuneration reporting and the scope of future digital outputs, with Audit Wales confirming these areas remain under active consideration.

Agenda Item 4 Update from Internal Audit

- Simon Cookson delivered an Internal Audit update, noting that the audit programme is substantially complete, with increased focus on operational service areas reflecting current organisational pressures. Simon reported that there has been a rise in high priority findings and limited assurance opinions, particularly in finance and workforce, alongside below target management response times. Members discussed these trends in detail, highlighting concern as to whether they reflect system pressures or a deterioration in control environments, and emphasised the need for further thematic analysis at an All-Wales level. The importance of triangulating audit findings with risk frameworks and improving the timeliness of management responses was also noted.

- Concerns were raised regarding cyber security risks, including levels of assurance and emerging vulnerabilities, and requested further insight and shared learning in this area. Overall, there was support for greater use of comparative audit data and strengthened cross-organisational learning to inform improvement.

Agenda Item 5 Counter Fraud

- Cheryl Hill was welcomed as the new Head of NHS Counter Fraud Service and provided an overview highlighting a continued focus on strengthening a proactive, intelligence led and preventative approach in response to emerging risks, particularly digital and procurement related fraud. Cheryl reported positive developments including the establishment of collaborative forums, strengthened governance arrangements, and a new service level agreement with the NHS Counter Fraud Authority. Progress over the past year was noted, including effective national collaboration that prevented a significant fraud loss. Variability in resourcing across organisations was acknowledged, alongside anticipated short term capacity pressures, with further work planned to review service structure and capability.

- Members welcomed the update and recognised the proactive work being undertaken, however concern was raised regarding resourcing levels, which the Chair noted should continue to be monitored at system level.

- Carl Window provided an update from the Counter Fraud Liaison Group, highlighting ongoing work to strengthen collaboration and consistency across NHS Wales through shared work planning, intelligence exchange and improved engagement with external partners such as local police forces. Carl noted emerging themes including inconsistencies in fraud risk assessment and the importance of ensuring risk owners, rather than counter fraud teams, are responsible for implementing controls. Progress was reported in relation to the National Fraud Initiative and collaborative approaches to data matching, alongside significant discussion on the introduction of mandatory counter fraud accreditation, including associated costs and the benefits of delivering training within Wales to reduce financial impact.

- Members noted the value of this collaborative and intelligence-led approach and supported continued sharing of learning across organisations. The Chair thanked Carl for his update and recognised the importance of the work, also expressing appreciation for his contribution as outgoing Chair of the Liaison Group.

Agenda Item 6 Update from the Director of Corporate Governance

- Trish Mills reported progress in strengthening governance capability across NHS Wales, including the launch of a mentoring programme to support succession and development, alongside well received masterclasses and plans for a second governance conference.

- Trish highlighted the introduction of the NHS Wales Operating and Accountability Framework from 1 April, structured around key pillars including quality, workforce, finance, performance and well-led, which remains under development as further detail on evidence requirements is established.

- Members were advised of new arrangements for senior led engagement and public accountability meetings, with feedback emphasising the need for a coordinated and proportionate approach to avoid excessive administrative burden. The framework is yet to be formally published pending ministerial input and will continue to evolve through the Director of Corporate Governance network.

PART B - ALL WALES AUDIT COMMITTEE CHAIRS

Agenda Item 7 AWACC Chair from September 2026 – Expressions of Interest

- The Chair invited members to consider putting themselves forward to chair the group as part of the forthcoming leadership transition. The Chair noted that the role would take effect from the autumn, allowing time for a handover, and requested expressions of interest ahead of the next meeting to support planning. The Chair assured members that the role is not overly onerous and highlighted that he has found it a rewarding experience.

Agenda Item 8.1 Deep Dive – Risk Management and Risk Appetite

- Julie Boalch, Assistant Director of Corporate Governance & Risk at Welsh Ambulance Service NHS University Trust, was welcomed to the meeting and facilitated a detailed discussion on risk appetite. Members reflected broadly that organisations are on a similar maturity journey, with well-developed frameworks, but highlighted ongoing challenges in embedding these into practice.

- Several members, noted that while risk appetite statements are established, they are not yet consistently influencing decision making or being operationalised across organisations. Stronger progress was identified where risk appetite is closely aligned to strategic objectives and supported by board assurance frameworks and dashboards, enabling more meaningful discussion and oversight.

- Members emphasised the importance of moving from theoretical frameworks to practical application, stressing the need for clear action planning, prioritisation and accountability to bring risks back within appetite. Improvements in risk management processes, including regular review and stronger scrutiny of risk registers, was recognised, although concerns remained around consistency and visibility of risks at all levels. Discussion also highlighted challenges in managing systemwide and interdependent risks across organisations. The consensus was that further work is needed to embed risk appetite into decision making, strengthen links to strategy and performance, and improve consistency and application across organisations, with value placed on continued shared learning across NHS Wales.

Agenda Item 8.2 Deep Dive - planning for next session (Board Assurance Framework, Risk Management & Appetite, Counter Fraud issues, Audit Committee role in partnership working, Clinical Audits, Financial sustainability/Digital)

- Members discussed options for the next deep dive session, noting a range of potential topics including board assurance frameworks, counter fraud, partnerships, financial sustainability and digital. Marian Jones proposed *a focus on digital transformation*, referencing recent and forthcoming Audit Wales work and the value of drawing out key national messages. Members supported this, endorsing digital as a priority, given its relevance across all organisations. Trish also suggested a future *deep dive on the broader role of Audit Committees in providing holistic assurance from "floor to board*," which members agreed would be a useful topic for a subsequent session. The group agreed that digital should be taken forward as the next deep dive, with further topics to be scheduled thereafter.

Agenda Item 12 Any Other Business

- Nuria Zolle raised a query regarding whether there is a consistent All-Wales methodology for assessing value for money in commissioning. Members acknowledged this as an increasingly important area, particularly given the scale of commissioned services and associated risks, but noted no established, standardised approach across NHS Wales.

- Marian Jones highlighted previous work on value-based approaches undertaken within Digital Health Care Wales (DHCW), while noting relevant experience sits within Swansea Bay. Michael Giannasi added that this remains a developing area, with current work in Powys supported by external partners identifying both emerging good practice and gaps. Members agreed the issue would benefit from further exploration within the wider governance network.

The date and time of the next meeting is on 17 July 2026 at 11am, via MS Teams.