Bundle Audit, Risk and Assurance Committee (Public) 3 September 2026

Agenda attachments

00 Agenda

09:30 - OPENING ITEMS

1 Chair's welcome, apologies and quorum

2 Declarations of interest

Item 02 Board member register of interests - updated 24 August 2026

3 Minutes of the last meeting held on 23 June 2026
(Confirmation of recording/transcript deletion of previous meeting)

Item 03 2026-06-23 unconfirmed ARAC PUBLIC Minutes

4 Action log and matters arising

4.1 Action log

Item 04.1 Action log

4.2 Committee AAA highlight report 23 June 2026

Item 04.2 ARAC AAA highlight report 23 June 2026

4.3 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:35 - Audit Wales

Item 05.1 Audit Wales Audit Risk and Assurance Committee update August 2026
Item 05.2 Audit Wales review of Non-Emergency Patient Transport Services (NEPTS) July 2026
Item 05.3 Audit Wales review of Digital Transformation
Item 05.3 Management response form Digital Transformation

6 10:05 - Internal Audit

Item 06.1 Internal Audit progress report September 2026
Item 06.2.1 Emerging Technology Adoption Final Internal Audit Report
Item 06.2.2 Digital Business Continuity Management Final Internal Audit Report

6.1 11:00 - COMFORT BREAK

7 11:15 - Good Governance Institute review - action plan

Item 07 GGi action plan to ARAC
Item 07 Annex 1 Board Effectiveness review report
Item 07 Annex 2 GGI action plan
Item 07 Annex 3 Strategic reporting and assurance framework

8 11:25 - Risk management and board assurance framework report
Annex 4 Board assurance framework, is available to view in the Reading Room

Item 08 Risk management report
Item 08 Annex 5 Principal risk trending data

9 11:40 - Policy governance update

Item 09 Policy governance update

10 11:45 - Assurance to ARAC on speaking up safely framework (from Chair of People and Culture Committee)

Item 10 Assurance to ARAC on speaking up safely framework (from Chair of People and Culture Committee)

11 11:50 - Assurance to ARAC on near miss and low harm intelligence framework (from Chair of QuEST Committee)

Item 11 Assurance to ARAC on near miss and low harm intelligence framework (from Chair of QuEST)

12 11:55 - Losses and special payments report (payments for the period 1 April - 31 July 2026)
Item 12 Losses and special payments (for period 1 April - 31 July 2026)
Item 12 Annex 1 Losses and special payments (summary of payments)

13 12:05 - Non-compliance with standing orders: publication of late papers
Item 13 Non-compliance with standing orders, publication of late papers

14 12:10 - Scheme of reservation and delegation of powers (SoRD) review
Item 14 Scheme of reservation and delegation of powers review
Item 14 Annex 1 Scheme of reservation and delegation of powers Schedule 1

15 12:20 - All Wales Audit Committee Chair's meeting report (AWACC)

15.1 CONSENT ITEMS (None)

15.2 12:25 - CLOSING ITEMS

16 Reflections

17 Any other business

18 Date and time of the next meeting: 3 December 2026 @ 09:30am

Length of Meeting:	03:00		[PUBLIC] AUDIT, RISK AND ASSURANCE COMMITTEE - 3 SEPTEMBER 2026					Deadline for Papers:	25 August 2026	Last good practice Exec Review: 19 August 2026
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**	**Notes**
			OPENING ITEMS							
		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	
09:30	00:05	3	Minutes of the last meeting held on 23 June 2026 (Confirmation of recording/transcript deletion of previous meeting)	Paper	Approval	Standing	n/a	Chair	n/a	
		4	Action log and matters arising 4.1 Action log 4.2 Committee AAA highlight report 23 June 2026	Paper	Discussion	Standing	n/a	Chair	n/a	
			FOR APPROVAL, ASSURANCE AND DISCUSSION							
09:35	00:30	5	Audit Wales 5.1 Audit Risk and Assurance Committee update August 2026 5.2 Audit Wales review of Non-Emergency Patient Transport Services (NEPTS) July 2026 (JB) 5.3 Audit Wales review of Digital Transformation July 2026 (KD)	Paper	Assurance	CoB	External Audit	Fflur Jones	n/a	
10:05	00:55	6	Internal Audit 6.1 Internal Audit progress report 6.2 Internal Audit reports: 6.2.1 Emerging Technology Adoptions *(Reasonable Assurance)* (KD) 6.2.2 Digital Business Continuity Management *(Reasonable Assurance)* (KD)	Paper	Assurance	CoB	Internal Audit	Osian Lloyd	Martyn Lewis	
11:00	00:15		COMFORT BREAK							
11:15	00:10	7	Good Governance Institute review - action plan	Paper	Endorsement	CoB	CorGov	Trish Mills	Julie Boalch, Alex Payne	
11:25	00:15	8	Risk management and board assurance framework report	Paper	Assurance	CoB	CorGov	Julie Boalch	n/a	
11:40	00:05	9	Policy governance update	Paper	Approval	CoB	CorGov	Trish Mills	Lisa Trounce	
11:45	00:05	10	Assurance to ARAC on speaking up safely framework (from Chair of People and Culture Committee)	Paper	Assurance	CoB	CorGov	Ceri Jackson, Trish Mills	Alex Payne, Sarah Harland	
11:50	00:05	11	Assurance to ARAC on near miss and low harm intelligence framework (from Chair of QuEST Committee)	Paper	Assurance	CoB	CorGov	Bethan Evans, Trish Mills	Alex Payne, Sarah Harland	
11:55	00:10	12	Losses and special payments report (payments for the period 1 April - 31 July 2026)	Paper	Assurance	CoB	FinCor	Chris Turley	Ed Roberts	
12:05	00:05	13	Non-compliance with standing orders: publication of late papers	Paper	Assurance	CoB	CorGov	Trish Mills	Alex Payne	
12:10	00:10	14	Scheme of reservation and delegation of powers (SoRD) review	Paper	Assurance	Ad Hoc	CorGov	Trish Mills	Alex Payne	
12:20	00:05	15	All Wales Audit Committee Chair's meeting report (AWACC)	Verbal	Assurance	CoB	n/a	Chair	n/a	
			CONSENT ITEMS (None)							
			CLOSING ITEMS							
		16	Reflections	Verbal	Discussion	Standing	n/a	Chair	n/a	
12:25	00:05	17	Any other business	Verbal	Discussion	Standing	n/a	Chair	n/a	
		18	Date and time of the next meeting: 3 December 2026 @ 09:30am	Verbal	Information	Standing	n/a	Chair	n/a	
12:30	**03:00**		**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
Chris Turley	Executive Director of Finance & Corporate Resources

Welsh Ambulance Services University NHS Trust
Board Member Register of Interests - Updated 24 August 2026

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 Academic Partnership 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	
		Cmgr FCMI - Chartered Manager and Fellow of Chartered Management Institute (UK)	Loyalty		
		CPMgr FIML - Certified Practising Manager and Fellow of Institute of Managers and Leaders (Aus/NZ)	Loyalty		
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	22 May 2023	
		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 (including 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	**Deputy Director of Nursing, Quality and Governance**	Nil Declaration		30 May 2026	

Welsh Ambulance Services University NHS Trust
Board Member Register of Interests - Updated 24 August 2026

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended
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	
		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	
Name	**Position**	**Declaration**	**Interest Type**	**Date Interest Started**	**Date Interest Ended**

Welsh Ambulance Services University NHS Trust
Board Member Register of Interests - Updated 24 August 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 * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019	
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021	
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, Planning and Performance**	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		09 September 2025	2026
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	
		Author of the book: '*Working With AI, Not Against It*' ~ commerically published and generates royalty income from sales.	Financial Interest	24 February 2026	
		Family member appointed to a post within Digital Directorate but will not be line managed by Director [appointment accepted 24/07/2026]	Any Other Interest	24 July 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			
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019	
		Member Royal College Nursing	Any Other Interest	01 August 2022	
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022	
		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 23 JUNE 2026 HELD AT THE CARDIFF MRD AND VIA TEAMS

Meeting started at 09:30

ATTENDEES

Peter Curran	Non-Executive Director and Committee Chair
Dr Umar Ahmad	Non-Executive Director
Prof Hayley Hutchings	Non-Executive Director *(deputising for Ceri Jackson - joined at Item 6)*
Julie Boalch	Assistant Director of Corporate Governance and Risk
Judith Bryce	Assistant Director of Operations
Wendy Herbert	Deputy Director of Quality & Putting Things Right
Trish Mills	Director of Corporate Governance/Board Secretary
Osian Lloyd	Head of Internal Audit, NWSSP
Rachel Marsh	Deputy CEO *(Deputising for Emma Wood – left at 11:02am)*
Liz Rogers	Deputy Director of People and Culture*(Deputising for Carl Kneeshaw*)
Chris Turley	Executive Director of Finance and Corporate Resources
Carl Window	Local Counter Fraud Manager

APOLOGIES

Fflur Jones	Audit Wales
Ceri Jackson	Non-Executive Director
Carl Kneeshaw	Director of People
Christian Fox	Trade Union Partner
Damon Turner	Trade Union Partner

OPENING ITEMS

1. CHAIR'S WELCOME, APOLOGIES AND QUORUM

1.1 The Chair welcomed everyone to the meeting. Apologies were received as set out above. Quorum was confirmed. The Chair observed that this would have been Carl Kneeshaw's last ARAC meeting and recorded his and the committee's appreciation for Carl's contribution and wished him well in his new role.

2. DECLARATIONS OF INTEREST

2.1 There were no other declarations recorded.

3. MINUTES OF THE LAST MEETING HELD ON 28 APRIL 2026

3.1 The minutes from the public meeting held on 28 April 2026 were received and approved.

4. ACTION LOG & MATTERS ARISING

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

ITEMS FOR ASSURANCE, DISCUSSION OR APPROVAL

5. 2025/2026 ANNUAL ACCOUNTS AND ANNUAL REPORT AND RECOMMENDATION TO TRUST BOARD

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 **2025-26 Annual Audited Accounts**

5.1.1 The committee received the Trust's Annual Accounts for 2025/26 and noted that the draft accounts had been submitted on 1 May 2026 in accordance with the required timetable. Members were advised that the Trust had achieved all statutory financial duties, including delivery of the revenue break-even duty, compliance with the capital expenditure limit and achievement of public sector payment targets.

5.1.2 The committee noted that the Trust had reported a small surplus of £78k, representing an effective break-even position. Total income and expenditure for the year were approximately £345.6 million, reflecting an increase of around £20.3 million compared to 2024/25. Members were advised that this increase was primarily attributable to pay awards, growth funding, National Insurance costs and recurrent investment in services.

5.1.3 Members noted that pay expenditure remained the Trust's largest area of expenditure, while non-pay costs had reduced as a result of efficiency and savings initiatives. The committee also received assurance regarding key balance sheet movements, including changes in capital assets, debtors, creditors, provisions and cash balances, together with the factors influencing those movements.

5.1.4 The committee noted that the Annual Accounts reflected the continued growth of the organisation and that the external audit process was nearing completion. Subject to consideration of Audit Wales findings and associated documentation, members were invited to recommend the Annual Accounts and associated Annual Report to Trust Board for approval ahead of the statutory submission deadline.

5.1.5 The Chair thanked the Executive Director of Finance and Resources and the finance team for the substantial work undertaken in preparing the Annual Accounts and commended the quality and detail of the documentation. The Chair also acknowledged the regular updates provided to the committee throughout the year regarding the Welsh Risk Pool (WRP) position.

5.1.6 The Chair sought assurance regarding the potential impact of volatility within the WRP on the Trust's ability to maintain financial balance. Members were advised that the position continued to be closely monitored, supported by Welsh Government funding arrangements and enhanced All-Wales scrutiny, with current forecasts indicating a potentially more favourable position for 2026-27 than originally anticipated.

5.1.7 Members also noted changes to the Putting Things Right redress arrangements, which had increased the threshold for claims managed locally by NHS organisations from £25,000 to £50,000. Assurance was provided that the associated financial pressures had been incorporated into the Trust's financial planning and budget-setting assumptions for this financial year, whilst recognising that the future volume and value of claims remained uncertain.

The committee endorsed that the Trust's draft Annual Accounts for 2025/26 be approved by the Trust Board at its meeting on 25 June 2026.

5.2 **2025/26 Annual Report**

5.2.1 Trish Mills presented the 2025/26 Annual Report, outlining its key components, including the Performance Report and Accountability Report, and confirmed that it had been prepared in accordance with the Welsh Government Manual for Accounts. Members noted that the document had been reviewed by Welsh Government and Audit Wales, with only minor amendments required, and that the Welsh language translation was in progress. Trish thanked colleagues across the organisation, including the corporate governance, finance, planning and people services teams, for their contributions to the report's development.

5.2.2 The Chair thanked Trish and all those involved in preparing the Annual Report, commending the quality and professionalism of the document. The Chair also welcomed the assurance provided by Audit Wales and noted the significant effort undertaken to produce such a comprehensive report.

5.2.3 Dr Umar Ahmad highlighted that the names and titles of two Non-Executive Directors appeared to be missing from page 97 of the Annual Report. Trish acknowledged the observation and agreed to review the document to confirm and address the issue if required.

5.2.4 Prof Hayley Hutchings welcomed the report and noted its comprehensive nature, noting however a minor accuracy issue, advising that her name and employment required amendment. Trish acknowledged the comment and agreed to review and correct it as appropriate.

The committee received and endorsed the Annual Report for approval by the Trust Board on 25 June 2026.

5.3 **Audit of Accounts Report, 2025-26 Accounts (Inc. Letter of Representation)**

5.3.1 Representing Audit Wales in the absence of Fflur Jones, Yvonne Thomas reported that the external audit of the 2025/26 Annual Accounts had been completed and that Audit Wales intended to issue an unqualified audit opinion, confirming that the financial statements presented a true and fair view of the Trust's financial position. Members noted that no significant matters or uncorrected misstatements had been identified, and that only minor disclosure amendments had been required. Audit Wales also confirmed that the Annual Report had been reviewed for consistency with the financial statements and Welsh Government guidance, with only minor typographical amendments identified. Members noted the positive audit outcome, which reflected the quality of the accounts' preparation process and the constructive working relationship between Audit Wales and the finance team.

5.3.2 Yvonne Thomas extended her thanks to Jill Gill and the finance team for their cooperation throughout the audit process. Yvonne noted that the positive audit outcome reflected the high standard of the Trust's finance function and acknowledged Jill's significant contribution in helping to shape and maintain those standards over many years. On behalf of Audit Wales, she wished Jill a long, enjoyable and well-deserved retirement.

5.3.3 The Chair welcomed the positive Audit Wales report, noting the absence of any uncorrected misstatements and the assurance provided regarding the quality and consistency of both the Annual Accounts and Annual Report.

The committee endorsed the Letter of Representation and agreed to recommend the Annual Accounts, Annual Report and associated audit documentation to Trust Board for approval.

6. INTERNAL AUDIT

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 Annual Head of Internal Audit Opinion

6.1.1 Osian Lloyd presented the Head of Internal Audit Opinion for 2025/26 and confirmed an overall opinion of reasonable assurance. Members noted that Internal Audit had completed 20 reviews during the year, comprising one no opinion report, two substantial assurance reports and 17 reasonable assurance reports, with no limited or unsatisfactory assurance opinions issued. Osian advised that governance, risk management and control arrangements were generally well designed and operating effectively, supported by established governance frameworks and responsive oversight arrangements. Whilst opportunities remained to further strengthen consistency of implementation, compliance monitoring, documentation, data quality and benefits realisation, the overall position reflected a positive control environment and continued organisational maturity. Members also noted that the number of audit findings, including high-priority recommendations, had reduced compared to the previous year, demonstrating ongoing improvement across the Trust.

6.1.2 Trish Mills welcomed the positive Internal Audit opinion, noting that the audit plan had been developed around the Trust's highest-risk areas and that the outcome reflected the strength of the organisation's governance and assurance arrangements. Trish highlighted the value of thematic analysis of audit findings to identify emerging trends and inform future improvement activity. Osian Lloyd added that further enhancements to the Internal Audit dashboard were planned, which would provide greater visibility of audit programme delivery and emerging themes throughout the year, supporting ongoing organisational learning and oversight.

6.1.3 The Chair welcomed the positive Head of Internal Audit Opinion and commended both Internal Audit and Trust staff for their contribution to the achievement of a full year without any limited or unsatisfactory assurance reports. The Chair also acknowledged the ongoing resource pressures facing the organisation and Internal Audit, welcomed the development of thematic analysis to support continuous improvement, and noted that the report would be presented to Trust Board for assurance.

6.2 Internal Audit Reports

The Chair noted that two internal audit reports, ***Emerging Technology Adoption*** and ***Digital Business Continuity***, had not been finalised in time for the meeting, and sought an update on their status and anticipated completion. Osian Lloyd advised that both reports were nearing completion and were

expected to be finalised and circulated shortly, noting that delays had arisen due to operational pressures and the need to consider additional evidence. Jonny Sammut acknowledged the delays, citing staff absences and the requirement to ensure that all relevant information was fully reflected within the reports, and confirmed that management responses had now been completed.

The committee agreed that the final ***Emerging Technology Adoption*** and ***Digital Business Continuity*** reports would be circulated to members for review outside of the formal meeting cycle, rather than being deferred to the September meeting.

6.2.1 Follow Up Review

Felicity Quance presented the Follow Up Review report and advised that good progress had been made in implementing internal audit recommendations, with strong governance and tracking arrangements in place. Members noted that 75% of recommendations arising from the 2024/25 audit plan had been closed by 31 March 2026, with the Trust's implementation rate exceeding the All-Wales average. Of the recommendations sampled for review, all but one were found to have been appropriately implemented, with the outstanding recommendation relating to winter modelling and forecasting having been reopened for further action. Members also noted the introduction of an enhanced digital tracking system to support real-time monitoring, reporting and improved data integrity.

Trish Mills welcomed the positive findings of the Follow Up Review and advised that the revised approach to monitoring recommendations throughout the year had enabled earlier intervention and course correction where required. Trish highlighted the benefits of improved evidence tracking and direct auditor access to supporting documentation, noting that these changes would strengthen assurance processes and support more efficient closure of recommendations. Trish also reflected positively on the Trust's strong audit culture and constructive relationship with Internal Audit, emphasising the organisation's focus on learning and continuous improvement.

6.2.2 Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management

Felicity Quance presented the CPAS Internal Audit Report, which received an overall rating of reasonable assurance. Members noted that governance arrangements, roles and oversight mechanisms were well established and operating effectively, with robust controls in place to support system testing and approval prior to implementation. The audit identified a key area for improvement relating to post-implementation monitoring, where greater formal assurance was required to demonstrate that system changes were operating as intended. Members noted that five

recommendations had been agreed with management, comprising one high-priority and four medium-priority findings, and that the increasing volume of system changes arising from the Clinical Model Transformation Programme further emphasised the importance of strengthening oversight arrangements.

Andy Swinburn welcomed the report and thanked Internal Audit for their constructive approach and insights. Andy noted that the increase in CPAS system changes, driven largely by the Clinical Model Transformation Programme, had highlighted the need to strengthen post-implementation monitoring arrangements. Andy confirmed that management accepted the audit findings and recommendations and would work collaboratively to further enhance oversight and assurance processes.

6.2.3 Vehicle Replacement Programme

Felicity Quance presented the Vehicle Replacement Programme Internal Audit Report, which received an overall rating of reasonable assurance. Members noted that the programme was supported by a Board-approved five-year procurement strategy, with strong governance, financial oversight and well-established funding arrangements in place. Of the 142 vehicles planned for procurement during 2025/26, 141 had been procured, with the remaining vehicle formally removed from the programme. The audit identified two medium-priority findings relating to project documentation and strategic performance reporting, whilst also highlighting the need to ensure risks associated with electric vehicle infrastructure capacity were appropriately reflected within programme risk registers. Management had accepted all recommendations and agreed implementation timescales.

Chris Turley welcomed the reasonable assurance rating and noted that the findings reflected a well-established and mature programme supported by strong governance arrangements. Chris advised that the scale of vehicle procurement activity had increased significantly in recent years as a result of additional Welsh Government investment and confirmed that management accepted the recommendations. Chris stated that the actions identified were relatively minor, building on previous work already underway, and was confident that they would be implemented and closed promptly. Chris also welcomed the assurance provided across all areas of the audit review.

The Chair welcomed the positive audit outcome and noted that, in his view, the report reflected a high level of assurance. The Chair acknowledged the significant increase in vehicle procurement activity during the year, recognising the additional complexity and workload associated with the expanded programme, and thanked Chris Turley and the wider team for their continued delivery and reporting to the committee.

6.2.4 Data Management Practices / Devolved Data

Felicity Quance presented the Data Management Practices / Devolved Data Internal Audit Report, which received an overall rating of reasonable assurance. Members noted strong local analytical capability, a positive data-aware culture and well-established digital infrastructure across the Trust. However, the audit identified that data management practices were highly decentralised, resulting in inconsistent reporting and limited assurance regarding data quality and accuracy. Examples were noted where differing reports contained conflicting information and externally shared data did not always meet established standards. Three recommendations were agreed with management, comprising one high-priority and two medium-priority findings, aimed at strengthening governance, consistency and oversight of data management arrangements across the organisation.

Jonny Sammut welcomed the reasonable assurance rating and advised that the report highlighted the need for a more consistent organisational approach to data management. Jonny emphasised the importance of establishing a single source of truth for data across the Trust and confirmed that all recommendations had been accepted. Members noted that work was already underway to strengthen data governance, standards, training and reporting arrangements, with plans to develop a more integrated enterprise data model and establish a data community of practice.

The Chair sought assurance that the use of decentralised data reporting tools and practices did not introduce additional cyber security or data governance risks to the Trust. Jonny advised that all data products remained within the Trust's Microsoft 365 environment, enabling appropriate organisational control and oversight. Jonny confirmed that there were no unauthorised routes for data extraction or external access and that existing controls provided assurance over the security and management of Trust data.

6.2.5 Estates Assurance: Fire Safety

David Butler presented the Fire Safety Internal Audit Report, which received an overall rating of reasonable assurance. Members noted the significant improvements made since the previous audit in 2021, including an increase in trained fire wardens, improved fire drill compliance and strengthened monitoring and reporting arrangements. Whilst recognising the challenges associated with managing fire safety across the Trust's extensive estate, the audit identified opportunities to further strengthen local controls, training, communication, risk assessment processes and reporting arrangements. No high-priority findings were identified, and Members noted that many of the issues raised were already being addressed by management.

Chris Turley welcomed the reasonable assurance rating, noting the significant improvements made since the previous audit and emphasising the importance of maintaining ongoing focus on fire safety given the Trust's extensive estate and inherent risks. Chris highlighted that further work was required to strengthen local operational compliance and reinforce that fire safety remained the responsibility of all staff.

The Chair welcomed the improved position since the previous audit and sought clarification on whether estate age influenced fire safety risks. David Butler advised that no direct correlation had been identified. Members queried the frequency of fire incidents and were advised that numbers remained very low. Members also sought assurance regarding fire warden coverage across sites, noting the arrangements in place to provide local leadership and oversight during emergency situations.

6.2.6 High Risk Records Policy

Felicity Quance presented the High Risk Records Policy Internal Audit Report, which received an overall rating of reasonable assurance. Members noted that the high risk records policy played an important role in supporting staff safety and operational decision-making, with effective alert mechanisms in place within the Computer Aided Dispatch (CAD) system and appropriate information-sharing arrangements with partner organisations. However, the audit identified weaknesses arising from reliance on manual processes, inconsistent application of controls and limited governance oversight. Concerns were noted regarding overdue annual reviews of high risk records, inconsistent record management practices and the absence of a formal reporting framework. Seven recommendations were agreed with management, comprising three high-priority and four medium-priority findings, with members noting that a planned digital solution was expected to address many of the issues identified.

Judith Bryce welcomed the audit findings and thanked Internal Audit and Trade Union colleagues for their contribution to the review. Judith acknowledged the areas identified for improvement, particularly in relation to governance, oversight and manual processes, and expressed confidence that the recommendations could be addressed through the forthcoming revision of the high risk record policy, implementation of a new digital high risk record system and strengthened reporting arrangements. Members noted that these developments would improve record management, oversight and assurance processes across the organisation.

The Chair sought assurance regarding the proposed digital high risk record app and its ability to address the issues identified by the audit. Judith advised that the app would significantly strengthen and streamline

the management of high risk records through improved recording, review, reporting and governance arrangements, replacing existing manual processes. Felicity added that Internal Audit had been provided with a demonstration of the app and noted that its built-in controls would improve data completeness, record management and compliance with policy requirements, addressing many of the weaknesses identified during the audit.

Members welcomed the proposed actions to address the audit findings and expressed reassurance regarding the planned transition from paper-based processes to a digital solution. Members also welcomed the proposed governance and oversight arrangements being developed to support the implementation and ongoing management of the system.

The committee received and noted the Annual Head of Internal Audit Opinion; and took assurance from the positive non-rated Follow Up Review Internal Audit Report and the reasonable assurance ratings of the Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management; Vehicle Replacement Programme; Data Management Practices / Devolved Data; Estates Assurance: Fire Safety; and the High Risk Records Policy Internal Audit Reports.

7. AUDIT WALES AUDIT RISK & ASSURANCE COMMITTEE UPDATE JUNE 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 Yvonne Thomas presented the Audit Wales update at June 2026. Members noted that work was progressing on the Digital Systems and Non-Emergency Patient Transport Services (NEPTS) reviews, both of which were expected to be reported to the committee in September 2026. Fieldwork was also underway for the Estates Management deep dive review, with reporting anticipated in September. In addition, planning had commenced for the 2026 Structured Assessment and a review of the 111 Service, both scheduled for reporting in December 2026. Members further noted the recent Audit Wales publication, NHS Urgent and Emergency Care System Under Constant Pressure, which provided useful context regarding the Trust's operating environment.

7.2 Jonny Sammut sought clarification on the anticipated timing of the Digital Systems Deep Dive report and requested advance notice of its publication to enable consideration of whether a more detailed briefing session for committee members would be beneficial ahead of its formal presentation to ARAC in September 2026. Yvonne acknowledged the request and confirmed that the feedback would be relayed to Flur Jones.

7.3 The Chair thanked Yvonne Thomas and Audit Wales for the update and noted the timescales for the forthcoming audit reviews. The Chair also welcomed the progress being made across the programme of work and acknowledged Jonny's request for advance sight of the Digital Systems Deep Dive report to facilitate further discussion, if required, ahead of its consideration by the committee.

The committee received and took assurance from the Audit Wales Audit Risk and Assurance Committee update June 2026.

8. AUDIT WALES DIGITAL DEEP DIVE (THIS ITEM WAS DEFERRED)

9. RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK 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.

9.1 Julie Boalch presented the Risk Management and Board Assurance Framework Report, outlining the Trust's 2026/27 risk management work programme and providing assurance on the management of principal risks. Members noted planned developments to strengthen the maturity of the Trust's strategic risk management arrangements, including the implementation of a revised Board Assurance Framework, enhanced risk appetite monitoring, development of strategic risks aligned to organisational objectives and improved reporting through dashboard technology. Members also noted updates to the Trust's principal risks, including increases to the risks relating to ambulance handover delays and delivery of the Trust's financial duty, reflecting current operational and financial pressures. Members welcomed the planned programme of work and the continued development of the Trust's risk management and assurance framework.

9.2 The Chair welcomed the proposed developments to the Board Assurance Framework and sought clarification on how risk appetite, risk scores and tolerances would be aligned to provide clearer assurance regarding whether risks were operating within acceptable parameters. Julie advised that further work was underway to develop risk thresholds and tolerances, review the alignment of principal risks to strategic objectives and risk appetite statements, and strengthen reporting arrangements to support more informed discussion and decision-making.

9.3 Trish Mills welcomed the progress being made, noting that the work represented a significant step forward in the Trust's risk management maturity and would support more effective use of risk appetite in decision-making, resource allocation and Board assurance. Trish also highlighted the substantial amount of work involved in developing an enterprise risk management system.

9.4 Jonny Sammut highlighted the importance of ensuring that principal risks were aligned to the most appropriate risk appetite statements, citing cyber security as an example where the current mapping may require further consideration. Julie agreed that the ongoing review of strategic objectives, risk appetite statements and risk mappings would provide an opportunity to refine these arrangements where necessary. Trish emphasised the value of embedding risk appetite into decision-making and resource allocation, noting that the work would support a more mature and integrated approach to risk management across the Trust.

9.5 The Chair welcomed the direction of travel and the significant progress being made to strengthen the Trust's risk management framework, Board Assurance Framework and risk reporting arrangements.

The committee considered and noted 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; received 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 noted the increase of two principal risk scores for Risk 223 to 25 (5x5) and Risk 139 to 12 (3x4).

10. AUDIT TRACKER REPORTING AND Q4 2025/26 UPDATE

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 proposed a revised approach to the monitoring and reporting of internal audit recommendations, reflecting the increasing maturity of the Trust's audit and assurance arrangements. Members noted that future reporting would focus on high-priority recommendations and limited assurance findings through the relevant board committees, supported by more intelligence-led reporting and thematic analysis, rather than detailed review of all outstanding actions by ARAC. The proposed approach would provide greater oversight of key risks, support continuous improvement and enable the committee to focus on emerging themes and organisational learning. Members welcomed the revised arrangements and the enhanced use of audit intelligence to strengthen assurance and governance processes.

10.2 The Chair queried the apparent disparity between the number of internal audit actions closed during the quarter and the number of revised target dates applied, seeking assurance that this did not indicate a deterioration in performance. Trish advised that no significant concerns had been identified through committee reporting and noted that the figures should be viewed in context, as they related to different audits and actions. Trish explained that

action owners were now setting more realistic implementation dates, supported by clearer evidence requirements and governance processes, which was improving the quality and robustness of action tracking and closure.

The committee noted the progress of the internal audit activity during Quarter 4 of 2025/26 financial year; endorsed the revised audit reporting approach; and received 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.

11. LOSSES AND SPECIAL PAYMENTS (1 APRIL 2025 TO 31 MAY 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.

11.1 Chris Turley presented the Losses and Special Payments report, highlighting activity for the full 2025/26 financial year and the opening months of 2026/27. Members noted the losses and special payments recorded during the reporting period and received assurance regarding the governance and oversight arrangements in place.

The committee noted the Losses and Special Payments Report for 1 April 2025 to 31 May 2026.

12. INTEGRATED GOVERNANCE PROGRAMME

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.

12.1 Trish Mills presented the integrated governance programme overview, outlining the development of a framework designed to strengthen the alignment between the Trust's external and internal accountabilities, strategic objectives, governance structures, assurance mechanisms and decision-making processes. Members noted that the programme sought to provide greater clarity regarding how assurance is generated, reported and escalated throughout the organisation, and how this informs the Board Assurance Framework. Trish advised that the work represented the first formal articulation of an integrated governance model for the Trust and would continue to evolve over the next two to three years, supported by a range of tools, guidance and governance improvements. Members welcomed the progress made to date and noted that the programme would support enhanced organisational oversight, accountability and assurance.

12.2 The Chair welcomed the integrated governance programme overview and highlighted the importance of establishing a framework that would remain sustainable and effective despite future changes in board or executive membership. Trish advised that the purpose of codifying the model was to create a clear and enduring governance framework that would provide consistency and continuity over time, while allowing supporting processes and tools to evolve. Trish added that whilst implementation would take place over a number of years, significant work had already been completed, and further developments were already underway to strengthen governance, assurance and accountability arrangements across the Trust.

The committee endorsed the integrated governance overview, subject to any further adjustments, to disseminate it more widely; and noted 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.

CONSENT ITEMS

13. AUDIT RISK AND ASSURANCE COMMITTEE AAA HIGHLIGHT REPORT 28 APRIL 2026 (no alerts)

13.1 The committee received the Audit Risk and Assurance Committee AAA Highlight Report from the meeting held on 28 April 2026, noting no alerts for escalation.

14. ALL WALES AUDIT COMMITTEE CHAIRS (AWACC) MEETING NOTES 1 JUNE 2026

14.1 The committee received and noted the meeting notes from the meeting of the AWACC held on 1 June 2026. The Chair reported that discussions had focused on risk management and risk appetite. Members heard that the Trust's approach was viewed positively and compared favourably with arrangements across NHS Wales, whilst also providing an opportunity to share learning and identify areas of good practice.

14.2 Trish Mills highlighted the value of the forum in facilitating broader discussions regarding the role of Audit Committees in providing assurance on governance and organisational effectiveness. Julie Boalch welcomed the opportunity to present the Trust's work and suggested that future discussions could explore the management of shared risks across NHS Wales.

CLOSING ITEMS

15. REFLECTIONS

15.1 The Chair reflected on the exceptionally positive assurance received throughout the agenda, particularly in relation to the Annual Accounts, Internal Audit Opinion and internal audit outcomes. The Chair congratulated colleagues on the high standards of governance, financial management and internal control evidenced during the year, whilst emphasising the importance of maintaining a focus on continuous improvement and avoiding complacency. The Chair also welcomed the significant progress being made in relation to integrated governance, risk management and assurance arrangements, and highlighted the constructive and collaborative relationships evident between the Trust, Internal Audit and Audit Wales as a key contributor to the positive outcomes achieved.

16. ANY OTHER BUSINESS

16.1 Chris Turley formally recognised Jill Gill's forthcoming retirement following almost 20 years of dedicated service to the Trust, paying tribute to her significant contribution to the Finance function, particularly her leadership and expertise in supporting the production of the Annual Accounts, and thanking her for her commitment and support over many years. The Chair echoed these sentiments on behalf of the committee, acknowledging Jill's diligence, professionalism and the considerable contribution she had made to the Trust's financial governance. Jill thanked colleagues for their kind words and reflected on her time, describing the organisation as having felt like a family throughout her career, and expressed her appreciation for the support she had received and said that she would greatly miss working with colleagues across the Trust.

17. DATE OF THE NEXT MEETING

17.1 The date and time of the next meeting will be on 3 September 2026 at 9:30am.

MEETING CLOSE: 1PM

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 23 June 2026** Trish Mills explained that ordinarily an annual review of the Standing Orders and SFIs would be brought to the committee following a Welsh Government review. However, no review has yet been received from Welsh Government and is expected at some point during the year, and that a revised Scheme of Reservation and Delegation may be brought forward in the meantime. Included within the September 2026 agenda. **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.	Complete
6.2/23062026	23 June 2026	**Internal Audit Reports**	Finalised Internal Audit reports for **Digital Business Continuity** and **Emerging Technology Adoption** to be circulated electronically to Audit Risk and Assurance Committee members for review and approval outside of the formal meeting cycle, upon completion of the reports.	Secretariat	3 September 2026	**Secretariat Update 24 June 2026** Final Internal Audit reports received and uploaded to iBabs reading room for committee members to view. Comments welcomed.	Complete

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	30 July 2026
Committee Meeting Date	23 June 2026
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS

ALERT (Alert the Board to areas of attention)

2025/26 annual report and audited accounts

1. The Committee reviewed and endorsed the 2025/26 Annual Report and Audited Financial Accounts. Audit Wales presented the ISA 260 report, confirming a very positive audit outcome, including an unqualified audit opinion and no uncorrected misstatements. Any identified issues were minor disclosure amendments only and had no impact on the reported position. Audit Wales confirmed the high quality of the financial statements and commended the team for their engagement. Members also noted the strong and constructive working relationship between Audit Wales and the finance team, contributing to a smooth and effective audit process.

2. The Annual Report had been reviewed by the board in draft form prior to the meeting and had also been reviewed by Audit Wales and Welsh Government, with only minor amendments required for consistency.

3. The Committee commended the teams for the significant work involved in the preparation and review of the 2025/26 Annual Report and Accounts.

4. The Committee recommended the Annual Report and Audited Financial Accounts to the board for approval. These were approved at an extraordinary Trust Board meeting on 25 June 2026, with the committee Chair providing a verbal update of ARAC's endorsement.

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

5. A **pre-meeting** was held with Audit Wales, Internal Audit and the committee Chair ahead of the meeting.

6. The committee noted a very positive committee meeting overall, **reflecting** strong assurance across internal control, financial management and governance arrangements. Members highlighted the high standard of work evident throughout, while emphasising the importance of maintaining momentum

and avoiding complacency as the organisation continues to evolve. The meeting provided an opportunity to formally recognise key contributions:

- The committee recorded its sincere thanks to Jill Gill, Head of Financial Accounting, for her significant contribution over many years, particularly her leadership and expertise in relation to the annual accounts. Members wished Jill every success and happiness in her retirement.

- The committee also noted that this was the final meeting for Carl Kneeshaw, Director of People, recording its appreciation for his valued contributions and service, and wishing him well in his future role.

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

7. The Committee received an **update from Audit Wales** on current and planned work, noting that the digital systems deep dive and the non-emergency patient transport review are expected to report in September. Future work includes estates management, the structured assessment and a review of the 111 service, due later in the year. Members noted the forward timetable and welcomed the opportunity to consider more detailed briefings in advance of forthcoming reports where appropriate. The update also drew attention to recent Audit Wales national publications on urgent and emergency care and planned care, which provide useful context on system pressures.

8. **The Head of Internal Audit Opinion and Annual Report 2025/26** was received by the committee and will be presented at the extraordinary meeting of the board on 25 June 2026. The overall opinion is one of reasonable assurance, meaning that the board can take reasonable assurance that governance, risk management, and internal control arrangements are suitably designed, operating and applied effectively.

   The audit plan for 2025/26 is largely complete, with two audits unable to make the deadline for this meeting. These will be circulated promptly for virtual approval to enable timely closure of the plan. The committee commended the excellent programme of audit reports and the fact that there were no limited or unsatisfactory assurance findings in year with two substantial assurance audits received. Members welcomed the positive performance indicators demonstrating timeliness of delivery and management response times.

9. The following internal audit reviews were received and discussed:

   (a) **Follow up review – reasonable assurance**. The committee noted strong overall progress in the implementation of audit recommendations, supported by effective governance and tracking arrangements. Performance compares favourably with the All Wales position, with a high proportion of recommendations closed. Members welcomed the revised approach to follow-up, which has enabled earlier oversight and course correction through the year, and improvements in the clarity and quality of supporting evidence. The introduction of enhanced digital tracking arrangements was also noted as a positive development, supporting greater transparency and efficiency.

   (b) **Clinical Prioritisation and Assessment Software (CPAS) Group: governance and change management – reasonable assurance**. The committee noted that governance structures are

well established and operating effectively, with strong controls in place prior to implementation of system changes. However, a key area for improvement was identified around post-implementation monitoring, with reliance on informal feedback rather than a more structured approach to assure that changes are embedded and delivering as intended. Members recognised the context of significantly increased system changes, driven by the Clinical Model Transformation programme and ongoing service demands, which heightens the importance of strengthening oversight arrangements. The Quality, Patient Experience and Safety Committee will review this audit at their next meeting.

(c) **Vehicle replacement programme – reasonable assurance**. The committee recognised the vehicle replacement programme as a well-established and mature area with strong governance, clear strategy and effective financial oversight. Members noted that delivery against the plan was largely on track, with almost all planned vehicles procured and the programme operating within agreed budgets and timescales. The discussion emphasised the scale and complexity of the programme, with a significant increase in activity and investment in recent years. This context was seen as important, with management highlighting that, given the maturity of the arrangements, a positive assurance outcome would have been expected.

A small number of medium-priority findings were identified, primarily relating to documentation and aspects of performance reporting. These were accepted by management and considered straightforward to address. The Finance and Performance Committee will review this audit at their July meeting.

(d) **Data management practices/devolved data – reasonable assurance**. The committee noted a limited assurance finding for one objective, reflecting weaknesses in consistency and oversight of data practices across the organisation. Discussion focused on two key themes highlighted by management. Firstly, the current decentralised analytics model has been outgrown, with strong local capability in place but increasing need to move towards a more co-ordinated enterprise data model. Secondly, the importance of establishing a single source of truth, with consistent data standards, definitions and reporting to reduce variation in interpretation and improve confidence in outputs.

The committee noted plans to address these issues, including the development of data standards, a data dictionary, and training, alongside the establishment of a community of practice to bring together analysts across the organisation. This will act as a precursor to a more formalised enterprise approach. Members sought assurance on cyber security risks and were reassured that all data products sit within the Trust's controlled Microsoft 365 environment, with no exposure from unauthorised tools. The risks identified relate to data consistency and interpretation, rather than cyber vulnerabilities. The Finance and Performance Committee will review this audit at their July meeting.

(e) **Fire safety – reasonable assurance**. The committee received a reasonable assurance report, noting significant improvements from previous audits and strengthened governance, training and compliance arrangements. Discussion highlighted the scale and complexity of the estate, with circa 117 sites across the organisation. Members recognised that this breadth inherently increases risk, but also requires a proportionate approach, given the varied nature of sites, ranging from

larger operational bases to smaller, often unoccupied stations.

It was noted that risk is mitigated in part by the limited public and patient presence on most sites, although the importance of maintaining robust controls was emphasised. The key area for further improvement relates to local operational compliance, ensuring that policies and procedures are consistently implemented across all locations. The Finance and Performance Committee will review this audit at their July meeting.

(f) **High risk records – reasonable assurance**. The committee received a reasonable assurance report, noting a number of control weaknesses, including reliance on manual processes, inconsistent documentation and gaps in governance and oversight, particularly around timely review of records. Management acknowledged the findings and outlined a clear improvement plan, centered on three key actions: updating the policy, strengthening governance and reporting arrangements, and introducing a new digital app.

The Committee discussed the app as a significant development, designed to replace paper-based processes, improve data quality and ensure completeness by requiring mandatory fields and audit trails. It will also support better monitoring, reporting and compliance with policy requirements. Members were reassured that the app has been tested and is expected to substantially strengthen controls and efficiency. The importance of ensuring appropriate digital and information governance oversight was highlighted, including alignment with wider data and system architecture to avoid unintended risks. The Finance and Performance Committee will review this audit at their July meeting.

10. The **losses and special payments report** received describing the 2025/26 outturn and early 2026/27 position with no issues raised.

11. The **integrated governance framework** was presented, setting out how accountability, governance structures, and assurance processes align with the Board Assurance Framework to provide a coherent assurance system. Members noted that, for the first time, the framework codifies how external accountabilities flow through the organisation and return as assurance to the board. The two-three year programme has received early validation from the Good Governance Institute review, confirming strong foundations with no requirement for major structural change. The Chair emphasised the importance of ensuring the model is robust, enduring, and able to withstand leadership changes, becoming embedded as an organisational standard. The committee's role was reinforced to maintain oversight of the effectiveness of integrated governance arrangements and the organisation's ability to derive assurance from them.

12. ARAC agreed to streamline **audit reporting**, reflecting improved organisational maturity. Oversight of actions will sit with relevant committees, with ARAC receiving risk-based, strategic reports focused on high-priority issues, delays, exceptions and limited assurance findings. Future reports will include clearer narratives, dashboards and thematic insights to highlight trends while reducing reporting burden.

13. In private session:

(a) The **Local Counter Fraud Service** 2025/26 Annual Report and work plan was approved, noting a balanced approach between proactive and reactive activity, increasing staff engagement, and

stable investigation volumes despite rising contact levels. The flexible, standards-compliant work plan focuses on emerging risks such as duplicitous working, remote working and asset management fraud, and will be monitored through aligned progress reporting. Members also discussed emerging risks, particularly around timesheet fraud and secondary employment in corporate roles, highlighting system and oversight challenges; while robust policies are in place, further audit work, improved manager awareness, and potential enhancements to electronic recording arrangements were identified to strengthen controls.

(b) The Committee noted routine **tender activity** and agreed that single tender waivers were appropriately used for sole suppliers, highlighting the need for more proactive, strategic oversight of such procurements, where appropriate.

RISKS

14. The committee noted the increase of two principal risk scores for Risk 223 to 25 (5x5) and Risk 139 to 12 (3x4).

15. Members supported the direction of travel for the 2026/27 risk programme, recognising the significant step change in strategic risk maturity with a focus on operationalising risk appetite through defined tolerances, alignment of risks to strategic objectives, and decision-relevant reporting linked to the implementation of a strategic Board Assurance Framework and supporting board dashboard.

16. Members acknowledged the complexity and scale of the work required to design and develop Electronic Risk Management and its integration with the BAF.

17. The committee noted the structured and phased delivery approach, including testing through the ELT and ARAC sub-group over the summer, a focused session at Committee in September, Board development in October, and any approvals by the Board in December 2026.

18. In private session it was noted that cyber and online symptom checker risks remain high, with robust controls in place and governance oversight through ELT. While cyber risk remains elevated due to the external threat environment, progress on a new symptom checker solution is expected to enable reassessment and potential closure.

COMMITTEE AGENDA		
2025/26 annual accounts and annual report	Head of internal audit opinion and annual report 2025/26; internal audit reviews as listed above	Audit Wales update
Risk management and board assurance framework update	Audit tracker Q4 update	Losses and special payments
Integrated governance programme update	ARAC AAA April meeting	All Wales Audit Committee Chairs update

COMMITTEE ATTENDANCE					
Name	**28 April 26**	**23 June 26[1]**	**3 September 26**	**3 December 26**	**4 March 27**
Peter Curran					
Dr Umar Ahmed					
Ceri Jackson		Hayley Hutchings			
Julie Boalch					
Judith Bryce					
Christian Fox		Hugh Parry			
Wendy Herbert					
Fflur Jones		Yvonne Thomas[2]			
Carl Kneeshaw		Liz Rogers			
Osian Lloyd					
Trish Mills					
Jonny Sammut					
Chris Turley					
Damon Turner					
Carl Window					

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] Rachel Marsh, Deputy CEO attended for this meeting for items 1-7
[2] For annual report and audited accounts, ISA 260 and Audit Wales update items

Archwilio Cymru
Audit Wales

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

Date issued: August 2026

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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: Complete**

  Audit work is complete, and our 'Audit of Accounts Report' has been issued. The accounts were certified by the Auditor General on 26 June 2026 and laid with the Senedd shortly afterwards

  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 examined the Trust's digital arrangements, with a particular focus on how it is investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Complete (report included in committee papers).

Expected committee date: September 2026

Review of Non-Emergency Patient Transport Service

- **Executive Lead:** Executive Director of Operations
- **Focus of the work:** This review examined 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:** Complete (report included in committee papers).

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 examined the effectiveness of the Trust's corporate arrangements to manage its estate, with a particular focus on how it is prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Draft report in clearance with the Trust.
- **Expected committee date:** December 2026

Structured Assessment 2026

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** Our 2026 structured assessment approach has been revised to place greater emphasis on effectiveness and impact. Our work, therefore, will focus on the Trust's 2025-28 Integrated Medium-Term Plan, considering both what has been planned and delivered, and the impact these actions are having on organisational finances, performance and outcomes. As part of our fieldwork, we will also gather high-level intelligence on how the Trust gains assurance over services delivered and support provided to it through the Joint Commissioning Committee (JCC), NHS Wales Shared Services Partnership (NWSSP) and NHS Wales Performance & Improvement (NHS P&I), where relevant.
-
- **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 we reported in 2025.
- **Status:** Planning
- **Expected committee date:** March 2027

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 struggling to control day-to-day costs despite continued funding increases / NHS Wales Finances Data Tool 2025–26	July 2026
NHS urgent and emergency care – a system under pressure	June 2026
NHS planned care – fit for the future?	June 2026

Since the last committee update, Audit Wales has published its Code of Audit Practice.

Catherine Mealing-Jones takes up role as Auditor General for Wales	July 2026
Code of Audit Practice	July 2026
Annual Report and Accounts 2025-26	June 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.

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Review of Non-Emergency Patient Transport Services

Welsh Ambulance Services University NHS Trust

July 2026

We have prepared and published this report under section 61(3)(b) of the Public Audit (Wales) Act 2004.

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Audit snapshot

What we looked at

1 We looked at how well the Welsh Ambulance Services University NHS Trust (the Trust) is set up to improve the Non-Emergency Patient Transport Service (NEPTS).

2 We have not looked at the NEPTS eligibility criteria, which are set by the Welsh Government, the role of the Joint Commissioning Committee (JCC), or the actions taken by the seven health boards.[1]

Why this is important

3 The Trust is responsible for running NEPTS, which is commissioned by the JCC, on behalf of the seven health boards in Wales.

4 NEPTS provides transport for people who are unable to make their own way to and from their medical appointments. It is an important service that ensures patients across Wales can access vital NHS treatment.

5 In recent years, the service has struggled with rising demand, limited resources, and a high number of on-the-day and last-minute cancelled journey appointments.[2] This has affected how efficiently the service runs.

6 In March 2025, the JCC approved The Future Vision for Non-Emergency Patient Transport in Wales 2030 (the Future Vision). This sets out five key priority areas to transform and improve NEPTS so it can meet future demand and provide good patient care.

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[1] The Joint Commissioning Committee (JCC) was established in April 2024 as a joint committee of the seven health boards in Wales. The JCC plans and commissions a range of specialised services and other healthcare services, including emergency medical services, on behalf of the seven health boards.

[2] Cancelled journeys are caused by a range of factors, including cancellations by patients, hospitals and due to lack of capacity within the Trust.

What we have found

7 The Trust has ambitious plans to improve NEPTS. These plans are aligned to the Future Vision and informed by performance data. However, expected benefits and outcomes are not yet defined, roles and responsibilities across partners are not fully agreed, and plans are not fully costed or prioritised.

8 The Trust is developing programme management arrangements for NEPTS improvements, but these are not yet fully established. The Trust and the JCC monitor actions and performance, but the Trust does not yet have clear sight of progress against the expected outcomes of the Future Vision across the system as a whole. Achieving those outcomes will require faster delivery, a clearer focus on benefits, and closer working with key partners.

9 Delivery of key improvement actions has been slower than planned in some areas. While performance has improved for some journey types, pressures such as rising demand, more complex patient needs, cancellations, delays, and communication issues continue to affect patient experience. Reporting does not consistently link improvement actions to milestones, benefits, or measurable impact. This makes it hard to assess whether changes are delivering the intended outcomes.

What we recommend

10 We have made four recommendations as part of this report. They are focussed on the following areas:

- making plans clearer by better defining outcomes and resources;
- setting up clearer programme, risk, and oversight arrangements;
- delivering improvements more quickly and working better with partners; and
- improving reports so they more clearly demonstrate the impact of actions.

Key facts and figures

570,000	The average number of NEPTS journeys each year in Wales.
640	Number of staff that work for NEPTS.
161	Number of volunteer car drivers.
42%	Percentage of journeys completed by private providers, taxis, and the voluntary and community sector (VCS) on behalf of WAST.
63,000	The number of short-notice cancellations (within four hours) in 2025.
14%	The number of on-the-day journey appointments cancelled during March 2025.
18,000	Number of additional journeys per year the Trust anticipates will be created by digital and rostering changes, once fully implemented.

Our findings

Planning for NEPTS improvements

Improvement plans are ambitious and align to the Future Vision, but benefits and shared responsibilities are not yet fully defined

11 The Trust has set out ambitious plans to modernise NEPTS in line with the Future Vision, mainly through its Integrated Medium Term Plan (IMTP) 2026-29. This plan identifies NEPTS as a key priority. This reflects ongoing concerns about cancellations, delays and overall patient experience.

12 The Trust's plans for NEPTS are based on a wide range of performance data and show a good understanding of current service pressures.

13 We reviewed the Trust's plans and supporting documents for delivering the five priority areas set out in the Future Vision. A summary of our assessment is set out in **Exhibit 1**. Taken together, these findings show that the Trust has identified the right improvement actions, but further work is needed to turn them into a deliverable programme.

Exhibit 1: Trust plans to deliver key aims of NEPTS Future Vision

Key strategic priority	Findings
Modernising for change: Adapting resources and approach to service delivery, to respond to the changing needs of the population and healthcare system.	Plans show a strong strategic intention to improve NEPTS, with clear actions on patient eligibility, staff rostering, fleet, and estates. Specific actions in the IMTP include: • using staff and transport more effectively through better rostering and planning so more patients can be transported; • agreeing the future shape of the ambulance care fleet to ensure it continues to minimise carbon emissions; and • using technology and equipment to improve safety and working standards. The Future Vision also highlights the need to review the patient transport eligibility criteria to ensure it better meets the need of NHS Wales. This review is the responsibility of the Welsh Government, the JCC, and health boards, but it is not yet clear when it will take place. In the meantime, the Trust has started to apply the existing eligibility criteria more strictly to help manage demand.
Digital transformation: Leveraging technology to improve co-ordination, efficiency and patient experience.	Plans include many digital changes to how bookings and patient communication are managed, such as linking the NEPTS booking system with health boards. But some actions do not have clear timelines or measures of success. Also, the Trust's plans to link its booking system with health boards' systems are not included in its digital plans or reported to the relevant committees.

Key strategic priority	Findings
Strategic integration: Ensuring non-emergency patient transport services are integrated within the wider healthcare system.	The Trust can point to examples of integration activity with system partners, including pilot work with Hywel Dda University Health Board to coordinate data, improve booking efficiency, and reduce short notice cancellations. But at the time of our work, the Trust had not set out a clear approach to learning from the system-integration pilots or how this would be applied more widely if successful.
Patient focused: Prioritising patient needs and feedback to enhance service delivery.	Although the Trust does not have a dedicated workstream for this pillar, it is taking action through other NEPTS improvement work. This includes improving access to booking systems and changing staff rosters to increase capacity. The Trust gathers feedback from patients through surveys, complaints, and patient stories. This feedback consistently highlights concerns about cancellations, which are affecting patient confidence in the service. The Trust expects its wider improvement programme to help reduce these concerns and improve the patient experience over time.
Working in partnership: Building strong collaborative relationships with partnership organisations to improve service outcomes.	The Trust's digital transformation actions aim to improve co-ordination and joint planning for NEPTS. By using new technology and offering more ways to book journeys, the Trust aims to simplify processes and strengthen how it works together with transport providers, patients, and health boards. This should help deliver a more efficient and responsive service.

Source: Audit Wales

14 While the Trust’s plans for NEPTS are set out in its IMTP 2026-29, there is no jointly owned implementation plan that clearly allocates responsibilities, milestones, and accountability across system partners. This means it is not always clear which actions the Trust will take on its own and which are the responsibility of health boards.

15 The Trust has mapped the Future Vision’s actions against its plans to show where actions align and where there are gaps. The gaps mainly relate to actions that need joint working with the JCC and partners. These include applying eligibility rules, providing alternative transport, and sharing data. Without a shared plan, it is difficult to set clear milestones and ensure accountability for delivery of the Future Vision across partners.

16 The Trust's plans recognise the need for changes to staffing, rostering, and service delivery to support improvements to NEPTS. But actions to improve NEPTS are largely non-cash releasing and have not been fully costed. This makes it hard to know if all planned improvements can be delivered within available resources (see **paragraph 21**).

Programme management and leadership

Programme and risk management arrangements for NEPTS are not yet fully developed or joined up, limiting assurance over delivery

Programme management

17 At the time of our work, the Trust was setting up a NEPTS Improvement Programme. The draft Project Initiation Document notes that governance and oversight will be through the Trust's existing Strategic Transformation Board. Key project management roles are clear and include the Executive Director of Operations as the Executive Sponsor and the Assistant Director of Operations (Ambulance Care) as the Senior Responsible Officer.

18 However, the NEPTS Improvement Programme is not yet fully operational. Key elements were still being developed at the time of our work. These include confirming workstream leads, agreeing formal reporting arrangements, completing the risk register, and agreeing SMART benefit measures.[3] These gaps make it hard to be fully assured that improvement activity is being prioritised, co-ordinated, monitored, and delivered in a way that will achieve the intended outcomes. Addressing these gaps is important given the financial pressures the Trust expects in 2026-27 (see **paragraph 21**).

Risk management

19 The Trust's Board Assurance Framework highlights strategic risks that could affect improvements to NEPTS. These include workforce capacity, financial pressures, and reliance on system partners. However, these risks are spread across a number of corporate risks and have not been brought together in one place. This makes it hard to see how NEPTS risks, improvement plans, actions, and assurances fit together.

[3] Specific, Measurable, Achievable, Relevant, and Time-Bound

20 The IMTP 2026-29 recognises that delivering improvement priorities alongside day-to-day services is a key risk. To mitigate this risk, the Trust states that it is prioritising improvement activity and strengthening programme management arrangements. However, it is not yet clear whether these actions will provide sufficient capacity to deliver all planned improvements within the timescales set out in the Future Vision.

21 The Trust faces significant financial pressures in 2026-27. These include delivering a £9 million savings requirement, rising non-pay costs, and limited funding for investment. While the Board Assurance Framework recognises financial pressure as a strategic risk, it is not clearly linked to NEPTS delivery. As a result, there is a risk that not all planned improvements to NEPTS can be funded and delivered.

22 These pressures mean the Trust needs to prioritise its improvement actions and make clear decisions about how it uses resources to support delivery. Without a stronger link between priorities, actions, resources, and risks, the Trust may take longer to deliver the improvements and intended outcomes. Effective risk management arrangements are important in supporting these decisions.

23 The draft Project Initiation Document includes a process for identifying, escalating, and monitoring NEPTS Improvement Programme risks. However, many risks were not fully developed at the time of our work. This limits assurance that programme risks are being managed in a consistent way.

Monitoring and oversight

Current reporting provides good visibility of operational performance, but limited assurance that improvement activity is delivering measurable benefits

Monitoring of improvement actions

24 NEPTS improvement work is monitored through actions set out in the IMTP 2026-29, with updates set out in quarterly performance reports to the Board and the Finance and Performance Committee. The Trust also reports to these fora on key work, such as re-rostering and service pressures affecting NEPTS.

25 At the time of our work, progress in delivering many of the Trust's NEPTS Future Vision actions was slower than planned. Many actions were described as being in development or at an early stage of delivery. For example, the need to re-roster, identified in 2019, was delayed due to the COVID-19 pandemic and the need to prioritise Emergency Medical Services. The project was then delayed further by more complex demand patterns, concerns about proposed shift patterns, discussions with trade unions, and the challenges of redesigning the service model. As a result, implementation is now planned for the first quarter of 2026-27. This suggests the Board needs to strengthen its oversight of improvement action delivery.

26 Performance is monitored by both the Trust and the JCC through its Commissioning Assurance Group (CAG). However, the Trust does not yet have an agreed way of tracking the cross-organisation changes that its NEPTS improvement plans depend on. This makes it hard for it to assess if those plans are on track. A Task and Finish Group, previously suggested by the JCC, could give the Trust clearer sight of delivery and a route to escalate delays that affect its actions.

Performance monitoring

27 The Trust routinely monitors NEPTS performance through dashboards, structured reports, and committee oversight. Performance data is shared regularly with the JCC, the CAG, and health boards, giving a clear view of trends and risks across the system.

28 Performance data shows that demand for renal transport is increasing and that patients' needs are becoming more complex. Together, these factors lead to greater use of ambulances. This can reduce ambulance capacity for outpatient appointments and patient discharges. Performance data shows improvement across key journey types, but pressures on the service remain.

29 Patient feedback for NEPTS consistently highlights concerns about cancellations and delays, which are affecting patient confidence in the service and the Trust. The Trust's performance reports also show that short-notice cancellations, delays, and poor communication remain key challenges.

30 Cancellations are caused by a mix of patient, hospital, system, and WAST capacity issues. There were 42,827 cancellations from January to March 2026. Over half were due to hospital and patient cancellations, showing that the Trust cannot address this issue on its own. However, capacity remains a key constraint for the Trust, with around one in six cancellations linked to no resources being available at the time of planning.

31 Around 37% of journeys were cancelled within four hours of travel between January and March 2026, leaving little time to reuse capacity or arrange alternatives. This shows the Trust needs to improve capacity planning, booking accuracy, and communication with patients, while also working with hospitals and health boards to reduce avoidable and late cancellations. The Trust is taking some action, including changes to rostering and digital systems, but these are not yet leading to consistent improvement in the areas of concern patients highlight most.

32 At the time of our work, reporting did not consistently link improvement initiatives to delivery milestones and expected benefits. This makes it hard to show the impact of specific actions on performance and patient experience. The Trust has set up a team within its Digital Services to focus on service improvement. However, senior managers recognise that the Trust's approach to change management needs to improve.

33 Taken together, the current monitoring arrangements provide good visibility of performance trends and areas of operational pressure. However, to support delivery of the Future Vision, routine reporting should more clearly show how priority improvement actions (including digital, rostering, and joint working with partners) are expected to reduce cancellations and improve communication. It should also set out delivery timescales and show progress against agreed benefits. This would strengthen accountability and improve assurance that improvement activity is delivering the intended benefits for patients and partners.

Recommendations

34 The following table details the recommendations arising from our work.

Strengthening planning and shared delivery

R1 The Trust should strengthen planning for NEPTS to support delivery of the Future Vision by clearly defining outcomes, responsibilities, and resource requirement. It should:

- **R1.1** Define measurable outcomes and benefits for key improvement actions (**paragraphs 13 and 33**).
- **R1.2** Agree a shared delivery plan with the JCC and health boards, setting out roles, responsibilities, and joint actions (**paragraphs 14 and 15**).
- **R1.3** Set out resource requirements and what can be delivered within available resources, including where trade-offs or prioritisation are needed (**paragraphs 16, 21, and 22**).

Strengthening programme and risk management

R2 The Trust should fully establish its NEPTS Improvement Programme and ensure risks and oversight arrangements support delivery. It should:

- **R2.1** Put in place core programme arrangements, including workstream leads, reporting, a full risk register, and measures of success (**paragraphs 17 and 18**).
- **R2.2** Ensure NEPTS risks are clearly aligned across programme and corporate risk frameworks (**paragraphs 19 and 23**).
- **R2.3** Strengthen links between priorities, risks, resources, and delivery plans (**paragraphs 20 to 22**).
- **R2.4** Agree system-level oversight arrangements with the JCC and health boards to support delivery of the Future Vision across organisations (**paragraph 26**).

Improving delivery and system coordination

R3 The Trust should accelerate delivery of improvement actions and strengthen coordination with partners. It should:

R3.1 Set out and deliver against a clear timeline for the actions to reduce cancellations and improve patient experience, including communication with patients (**paragraphs 25 and 29 to 31**).

R3.2 Evaluate and apply learning from system-integration pilots (**paragraph 13**).

Strengthening performance reporting, oversight, and impact

R4 The Trust should strengthen reporting and Board oversight to clearly show the impact of improvement actions on performance and patient experience. It should:

R4.1 Link improvement actions to milestones, expected benefits, and outcomes in routine reporting, enabling the Board to track delivery (**paragraphs 32 and 33**).

R4.2 Track and report progress against key measures, including cancellations, timeliness, and patient experience, so the Board can assess whether performance is improving (**paragraphs 27 to 31**).

R4.3 Use performance and patient feedback to assess whether improvements are delivering the intended impact and support the Board in challenging and refining the approach where progress is limited (**paragraphs 29 to 33**).

1 About our work

Scope of the audit

We looked at how well the Trust is set up to deliver improvements to NEPTS. In particular, we considered how well the Trust's plans align to the ambitions of the Future Vision. We also considered how the Trust was managing, monitoring, and overseeing progress against its plans and their impact on NEPTS performance.

Audit questions and criteria

Questions

Our audit addressed the following questions

- Does the Trust have clear and realistic plans to deliver the aims set out in the NEPTS Future Vision 2030 around modernising for change?
- Has the Trust reviewed and costed the resources needed to ensure the effective delivery of the NEPTS Future Vision 2030?
- Are there clear leadership and oversight arrangements to ensure the successful delivery of the NEPTS Future Vision by 2030?
- Is the Trust effectively monitoring NEPTS performance and delivery of its improvement plans?

Criteria

We assessed the Trust's approach against audit criteria shaped by key strategic plans, including The Future Vision for Non-Emergency Patient Transport in Wales – 2030.

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes, including the Monthly Integrated Quality and Performance Report and Integrated Medium Term Quarterly Monitoring Report.
- Key strategies and plans, including the Trust's Integrated Medium-Term Plan (2026-29), and the draft Project Initiation Document for the NEPTS Improvement Programme;
- Key risk management documents, including the Trust's board assurance framework and operational risk registers.
- Relevant Internal Audit reports, including Capacity Management Plan (2026).

We interviewed the following key stakeholders:

- Executive Director of Operations;
- Executive Director of Strategy, Planning and Performance;
- Assistant Director of Operations (Ambulance Care);
- Assistant Director of Digital;
- Head of Financial Management;
- Director of Commissioning for Ambulance Services and 111 (JCC).

We also reviewed data available from the Trust's regular performance reports. We have not audited the validity of the data from this source.

2 Management Response

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R1 The Trust should strengthen planning for NEPTS to support delivery of the Future Vision by clearly defining outcomes, responsibilities, and resource requirement. It should: **R1.1** Define measurable outcomes and benefits for key improvement actions.	The Trust accepts this recommendation and has already established a NEPTS Improvement Programme, supported by appropriate governance, reporting into Strategic Transformation Board. TOR are established and have	April 2027	Assistant Director of Operations (ADO), Ambulance Care who is also Senior Responsible

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	been agreed by STB. Outcomes and resource responsibilities will be reported through the programme by April 2027. Evidence will be via Highlight reports, AAA – from the improvement programme to STB.		Officer (SRO) – NEPTS Improvement Programme
R1.2 Agree a shared delivery plan with the JCC and health boards, setting out roles, responsibilities, and joint actions.	The Trust will engage with JCC and will provide meeting minutes/correspondence to evidence engagement.	December 2026	ADO, Ambulance Care
R1.3 Set out resource requirements and what can be delivered within available resources, including where trade-offs or prioritisation are needed.	As R1.1	April 2027	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R2 The Trust should fully establish its NEPTS Improvement Programme and ensure risks and oversight arrangements support delivery. It should:			
R2.1 Put in place core programme arrangements, including workstream leads, reporting, a full risk register, and measures of success.	The Trust accepts this recommendation and has already established a NEPTS Improvement Programme, supported by appropriate governance, reporting into Strategic Transformation Board. ToR are established and have been agreed by STB. A risk register has been developed as part of this programme and is reviewed at each programme board meeting. A workstream for benefits mapping is set to deliver	April 2027	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	in September 2026 and this will also be reported to STB. Evidence will be via Highlight reports, AAA – from the improvement programme to STB.		
R2.2 Ensure NEPTS risks are clearly aligned across programme and corporate risk frameworks.	As R2.1	April 2027	ADO, Ambulance Care
R2.3 Strengthen links between priorities, risks, resources, and delivery plans.	The improvement programme workstreams have begun to review this and this will continue to be reviewed through the programme structures that are in place. Any requirements not deliverable within available resources will be routinely	April 2027	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R2.4 Agree system-level oversight arrangements with the JCC and health boards to support delivery of the Future Vision across organisations.	highlighted to STB and also placed into consideration for future IMTP cycles. Evidence will be via Highlight reports, AAA – from the improvement programme to STB and through notes of STB meetings. WAST will establish regular engagement with commissioners to provide updates on both progress of the improvement programme and delivery of the future vision. However, it our view is that this will require JCC to lead this process as lead commissioners. This will be evidenced through minutes from these commissioning fora.	October 2026	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R3 The Trust should accelerate delivery of improvement actions and strengthen coordination with partners. It should:			
R3.1 Set out and deliver against a clear timeline for the actions to reduce cancellations and improve patient experience, including communication with patients.	The improvement programme will provide a clear timeline for agreed actions and patient engagement, which will be reported into STB. Progress with reducing cancellations will be reported through the MIQPR. Evidence will be provided through AAA/highlight reports into STB and the MIQPR.	April 2027	ADO, Ambulance Care
R3.2 Evaluate and apply learning from system-integration pilots.	We will ensure that this is built into the relevant workstreams within	April 2027	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	the improvement programme and reflected within the benefits realisation plan.		
R4 The Trust should strengthen reporting and Board oversight to clearly show the impact of improvement actions on performance and patient experience. It should:			
R4.1 Link improvement actions to milestones, expected benefits, and outcomes in routine reporting, enabling the Board to track delivery.	This will be implemented through the improvement programme; We will ensure that this is reported quarterly through the improvement programme into the STB and to	April 2027	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	Trust Board through reporting on IMTP delivery and via the MIQPR. Evidence will be provided through AAA/highlight reports into STB and the MIQPR.		
R4.2 Track and report progress against key measures, including cancellations, timeliness, and patient experience, so the Board can assess whether performance is improving.	As R4.1		ADO, Ambulance Care
R4.3 Use performance and patient feedback to assess whether improvements are delivering the intended impact and support the Board in challenging and refining	We have already established robust arrangements to capture, review and report patient feedback through patient surveys, feedback channels via SMS messaging, CMP surveys and	April 2027	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
the approach where progress is limited.	through PECI engagement with patients. We will ensure that this process remains able to capture the required information as delivery of the improvement programme progresses. This will be reported and reviewed at the WAST Operations Directorate Senior Operations Team (SOT) and Senior Leadership Team (SLT) meetings. Evidence will be provided through the NEPTS Quality Dashboard and minutes/AAA from the above meetings.		

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Archwilio Cymru
Audit Wales

Digital Transformation

Welsh Ambulance Services University NHS Trust

July 2026

About us

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Audit snapshot

What we looked at

1 We looked at how the Welsh Ambulance Services University NHS Trust's (the Trust) approach to digital transformation is supporting service improvement. This included its approach to strategy, leadership and skills development. And we considered how the organisation manages risks around digital infrastructure, cyber resilience and artificial intelligence (AI).

Why this is important

2 Digital technology is a key enabler to many of the aims of A Healthier Wales. That plan says that new technologies and digital approaches will be an important part of the future whole system approach to health and care.

3 However, achieving digital transformation is challenging. It requires investment, the right infrastructure, and staff engagement and training. Systems need to communicate with one another, and organisations must manage ever-growing risks around cyber resilience.

4 Digital transformation isn't just about technology, it's about culture and leadership. The boards of NHS bodies have a key role in approving and owning the organisation's digital strategy. Boards also need assurance that digital transformation is being managed safely and effectively, and that investment is securing the intended benefits.

What we have found

5 The Trust has clear digital ambitions and strong leadership. Its Digital Plan aligns with national priorities, but does not set out clear milestones, ownership, or resource needs. It lacks a clear view of digital maturity. This, together with some weaknesses in reporting, makes it hard to track progress.

6 The Trust regularly reviews its strategic digital risks and has a range of cyber resilience controls. But longer-term planning around digital infrastructure and governance for AI is not clear enough to provide full assurance.

7 The Trust recognises the importance of digital skills and capacity, but its approach is not yet joined up. Skills are not assessed consistently, training is fragmented, and workforce planning is not based on a clear baseline.

8 The Trust recognises the importance of engagement and involvement. Staff and service users are involved in some projects, but this is not consistent across all digital developments. Although the Trust is committed to reducing digital exclusion, it does not have a clear plan or a dedicated lead to drive this work.

9 The Trust is delivering digital projects and working with national partners. But it does not have a clear, joined-up view of progress, risks, or benefits. Future plans for digital investment and evaluation are unclear, which limits assurance that digital work will deliver lasting value.

What we recommend

10 We have made nine recommendations to the Trust. These focus on:

- Strengthening the Digital Plan with clear milestones, ownership, resource needs, and success measures.
- Improving reporting to the Board, including clearer progress measures and risk updates.
- Strengthening Board oversight of digital transformation risks.

- Developing a costed digital infrastructure replacement plan with clear timelines and long-term investment needs.
- Introducing a clear AI strategy and governance framework.
- Building digital workforce capability through better skills assessment and training.
- Strengthening user engagement and digital inclusion.
- Setting out clear, costed investment plans beyond 2025-26.
- Introducing consistent post-implementation reviews to assess value.

Key facts and figures

Between 2021-22 and 2024-25, the Trust invested around £58.1 million in digital revenue and £16.9 million in digital capital.

Of the Trust's 4,400 staff, only 22 have completed the Health Education and Improvement Wales (HEIW) Digital Capability Framework self-assessment.

The Trust has not completed a Health Information and Management Systems Society (HIMSS) Electronic Medical Record Adoption Model (EMRAM) assessment or Infrastructure and Adoption Model (INFRAM) assessment.

In 2025-26, the Trust reported no cyber incidents under the Network and Information Systems Regulations 2018.

Our findings

Strategy, planning, and leadership

The Trust shows clear digital ambitions and strong leadership, but gaps in planning, baseline measures, and reporting limit its ability to track progress and outcomes

Digital strategy and plans

11 The Board approved the Trust's Digital Plan - 'Our Digital Plan' - in July 2024. The plan outlines the Trust's aim of using simple, reliable digital technology and data to improve services and deliver high-quality care. To deliver this vision, the Trust has set out five key digital and data pillars[1] in the plan, one of which is 'transformation'. The plan aligns with national priorities, the Trust's long-term strategy and vision, and its Integrated Medium-Term Plan (IMTP) 2025-28. The Trust says that stakeholders were involved in developing the plan. But the plan does not clearly show who was involved or how their feedback shaped the Trust's digital priorities.

12 The plan reflects the Trust's view of its digital strengths and weaknesses, drawing on internal and external reviews and some benchmarking. It also describes the Digital Directorate in detail, including its structure, ways of working, and key areas for improvement. But the plan does not include a formal digital maturity assessment or set a clear baseline for the Trust. This makes it hard to track progress, demonstrate impact, and compare performance with other organisations.

[1] Its five digital and data key pillars are: (1) Everyday Essentials, (2) Security, Safety and Cyber, (3) Digital Pioneers, (4) Transformation, and (5) Data, Information and Insight.

13 The Trust's digital priorities are set out in the Digital and Data Roadmap within its IMTP 2025-28. The roadmap gives a clear picture of what the Trust aims to deliver in year one but provides less detail for years two and three. Also, it does not clearly assign ownership, resource needs, or how success will be measured. This makes it hard to understand how delivery will be managed and progress assessed.

Board ownership of digital transformation

14 The Board understands and supports the Digital Plan. Senior leaders also recognise the importance of digital for the Trust's long-term strategy. Digital issues are discussed regularly by the relevant committees (see **paragraph 17**). Board members have taken part in training on some areas, such as cyber security. More training is planned on areas such as AI and data. This helps the Board provide challenge and oversight. But more regular training would help Board members provide consistent leadership and challenge on digital matters.

15 The Chair of the Finance and Performance Committee is the Trust's Board-level Champion for Digital. This helps maintain the profile of digital at Board. The Chair also represents the Trust on the All-Wales Independent Member Digital Network. The Director of Digital Services represents the Trust on the All-Wales Directors of Digital forum. These groups provide useful opportunities to share learning and take part in national digital discussions that inform the Trust's digital change work.

Roles, responsibilities and accountability

16 The Trust has strong digital leadership and clear roles. The Director of Digital Services leads the Digital Plan and assistant directors lead day-to-day work.

17 The Board has a reasonable understanding of progress in digital work. Updates are provided every two months to the Finance and Performance Committee, with key issues raised at Board meetings through highlight reports. But these updates do not always include key information, such as progress against milestones, changes in risk, or if programmes are on track. Coverage is also uneven, with some areas reported in detail and others only briefly described. This makes it hard to see overall progress across the Digital Plan. Reports also tend to focus on activity rather than outcomes, and the link to strategic priorities is not always clear. More consistent reporting, clearer measures, and the use of simple visuals would help the Board monitor delivery more effectively.

18 Digital reports provide detailed updates on a wide range of programmes and activities, but the language is often technical. Specialist terms and system names are used, with limited explanation of what they mean or why they matter. This can make it hard for some committee members to quickly understand progress, identify emerging issues, and focus on the most important risks. Our observations of meetings found that discussions on digital matters are brief, with limited questioning and challenge. This suggests that the complexity of the reports may be limiting effective scrutiny.

Identifying and managing risks

The Trust regularly reviews its strategic digital risks and has a range of cyber resilience controls, but gaps remain in infrastructure planning and AI governance

Strategic digital risks

19 The Trust's Board Assurance Framework (BAF) includes two digital strategic risks: the unauthorised or inappropriate use of AI, and a major cyber-attack that could disrupt systems and services. Both risks are rated high, with scores of 16 and 20 in that order. The Board and Finance and Performance Committee review them regularly.

20 Reports list controls, track actions, and include some progress measures. But they do not clearly show how well controls are working or how actions are reducing risk. Clearer reporting on their effectiveness would strengthen Board oversight.

21 The BAF does not include a specific risk on digital transformation. This means the Trust may not fully consider risks that could affect delivery of its Digital Plan, such as delays or limited resources. As a result, the Board may find it hard to make informed decisions, target resources, and demonstrate clear management of strategic digital risks.

Digital infrastructure risks

22 The Digital Plan focuses on making sure the Trust's digital infrastructure is reliable and supports day-to-day services. It highlights the need for dependable systems, devices, and core technology to help staff do their jobs effectively and make sure patients can rely on digital services. But it does not explain how or when digital infrastructure will be upgraded.

23 The Trust is making progress in updating infrastructure in some areas. It is replacing high-risk systems, installing new servers for critical services, and moving some systems to the cloud. These actions show that the Trust responds when risks are identified. But most of this work is managed through separate projects, often linked to available funding. There is no single view of key gaps across the digital estate or a long-term funded plan for replacing outdated or unsupported systems. This makes it hard to assure the Board that infrastructure risks are managed in line with long-term goals.

Cyber resilience

24 The Trust has a Cyber Improvement Plan, which brings together actions from different reviews including Network and Information Systems (NIS) directive audits. Most high-risk actions are complete or now part of business as usual. At the time of our review, the Trust was updating the plan to better reflect operational and clinical impact.

25 The Trust provides cyber reports every two months to the Finance and Performance Committee. These reports cover cyber incidents and day-to-day issues. The March 2026 report notes a small number of incidents, including one involving a third-party supplier. The incident was found and resolved quickly using existing processes. However, the reports use technical language and limited use of plain English. This may make them harder for non-specialist Board members to fully understand the information.

26 The Trust uses a range of controls to improve cyber resilience. These include system updates, vulnerability checks, and testing recovery plans for critical systems such as 999 and 111. Cyber risks are also considered when new systems are introduced. These actions have reduced some risks, such as improving device security and reducing unused accounts. But some issues remain. Reports highlight weaknesses during busy periods, ongoing phishing attacks, and low take-up of cyber training. These issues reduce the overall effectiveness of controls.

Artificial intelligence

27 The Trust recognises that AI offers benefits, but its current use is limited. The Trust mainly uses AI to support staff with administrative tasks and data analysis. It is not used to support clinical decision-making. The Trust does not yet have a clear strategy setting out how it will use AI to improve efficiency and effectiveness and support change and innovation.

28 Positively, the Trust has recorded an AI risk in its BAF (see **paragraph 19**). The risk covers the data protection, legal, and reputational issues that could arise from AI use. The Trust is mitigating the risk through guidance, monitoring, and an AI Steering Group. But as use of AI grows, the Trust will need stronger governance to manage clinical, operational, and ethical risks.

Digital skills

The Trust recognises the importance of digital skills and capacity, but stronger assessment, training, and workforce planning are needed to support digital transformation

Assessing digital skills

29 The Trust recognises the importance of digital skills but does not assess them in a consistent or comprehensive way. Only 22 staff have completed the HEIW Digital Capability Framework self-assessment. This is low for an organisation of around 4,400 staff. The framework focuses mainly on basic IT confidence and does not cover the wider skills needed for digital transformation. There is no evidence that the Trust assesses these broader skills in other ways. As a result, it does not have a clear picture of its overall digital capability. This makes it hard to target training, allocate resources, and plan digital change.

Developing digital skills

30 The Trust wants to develop a digitally skilled workforce but does not yet have a clear, joined-up training programme. The Digital Plan and Strategic Workforce Plan both recognise the importance of digital skills and set an ambition for a digitally capable workforce. The Strategic Workforce Plan also commits to developing a Digital Skills Strategy for 2025–2030. But there is limited detail on what this strategy will include, how skills will be assessed, how gaps will be identified, or how training will be targeted and measured.

31 The Trust provides access to learning tools such as online courses, e-learning, and training linked to new systems. But these are not yet brought together into a single structured programme. As a result, the Trust cannot be confident that its approach will provide the skills needed to support digital transformation effectively.

32 At the time of our work, the Trust had 109.22 whole-time equivalent staff in digital roles. The Trust was also strengthening its Digital Directorate by recruiting a Head of Business Change and Benefits. The Digital Plan recognises the importance of having the right skills and capacity in the Digital Directorate. But it does not set out a clear baseline of digital skills and capacity. This makes it hard to assess if current staffing levels are sufficient to meet the Trust's digital needs.

Collaboration and involvement

The Trust recognises the importance of engagement and digital inclusion, but gaps in approach, leadership, and delivery limit the impact on digital transformation

Staff and service user involvement

33 The Trust involves staff, patients, and service users in some digital work and has received positive feedback from specific projects. It is also introducing new approaches, such as the Innovation Lab and the Digital Transformation and Innovation Programme Board. While this is positive, the Trust does not yet have a single clear approach to involving stakeholders and using their feedback to shape its digital priorities.

Reducing digital exclusion

34 The Trust's Digital Plan aims to prevent digital exclusion and make sure its digital services meet the needs of people with different levels of digital access and confidence. Its strong emphasis on user-friendly design and reducing barriers to access shows the Trust's commitment to improving digital inclusion.

35 But there is limited evidence of digital exclusion being reduced in practice. The Trust does not yet have a clear digital inclusion plan that sets out its aims, actions, or how success will be measured. Also, there is no dedicated lead for this work. The Trust is exploring how to strengthen this area, including improving reporting to the Digital Transformation and Innovation Programme Board and the Board.

Using digital developments to support service transformation

The Trust is delivering digital improvements, but gaps in planning, funding clarity, partnership working, and evaluation make it hard to show long-term impact and value

Investment in digital transformation

36 The Digital Plan sets out why digital investment matters and what the Trust aims to achieve. The IMTP 2025-28 shows how this supports the Trust's wider strategy. A separate paper to the Finance and Performance Committee included high-level cost options. But these documents do not clearly show the full cost of delivering the Digital Plan over time. They also do not explain how funding links to priorities or how delivery will be funded beyond these high-level figures.

37 **Exhibits 1** and **2** show that the Trust has invested significantly in digital in some years, but spending has varied between years. Between 2021-22 and 2023-24, capital investment ranged from £4.2 million to £6.6 million. In 2024-25, capital spending fell sharply to £1.6 million, suggesting fewer large projects were funded. Revenue spending increased steadily during the same period, rising from £10.5 million in 2021-22 to £15.5 million in 2024-25. This suggests an increased focus on running, maintaining and supporting existing digital systems.

38 The Trust has set out planned digital spending for 2025-26, with £2.2 million for capital and £17.3 million for revenue. However, it has not provided capital figures for 2026-27 or 2027-28 and has shared little information on revenue funding beyond 2025-26. This makes it difficult to assess if the Trust will have enough funding in future years to maintain existing systems or deliver its planned digital improvements.

Exhibit 1: Annual capital and revenue investment in digital (2021-22 to 2024-25)

Financial year	Capital (£m)	Revenue (£m)
2021-22	4.5	10.5
2022-23	4.2	12.6
2023-24	6.6	13.2
2024-25	1.6	15.5

Source: Trust supplied data

Exhibit 2: Planned levels of capital and revenue investment in digital (2025-26 to 2027-28)

Financial year	Capital (£m)	Revenue (£m)
2025-26	2.2	17.3
2026-27	-	-
2027-28	-	-

Source: Trust supplied data

Local and regional digital projects

39 The Trust is delivering a range of local digital and data projects to improve services, support staff, and increase efficiency. These include:

- improving NHS 111 by introducing new features such as online symptom checkers and virtual assistants;
- upgrading dispatch and control room systems;
- refreshing the electronic Patient Care Record (ePCR);

- updating cloud-based rostering and timesheets; and
- improving the use of data and performance reporting.

40 The Trust is also testing simple AI tools, mainly to support staff rather than clinical decision-making (see **paragraph 27**).

Adopting national digital systems

41 The Trust works with national and system partners to support delivery of its Digital Plan. It engages with the Welsh Government, Digital Health and Care Wales (DHCW), and national clinical groups and programmes on areas such as NHS 111, emergency response, and performance reporting. It also takes part in national digital programmes and data sharing, showing a commitment to the 'Once for Wales'.

42 Joint working with partners is stronger at a project level than at a strategic level. Reports describe many partner-led or partner-supported projects, but do not always clearly show roles and responsibilities, how partner delivery is overseen, or how partner risks are managed.

43 The Trust is beginning to improve its partnership governance arrangements. But it needs to do more to improve oversight of partner-led digital work and make better use of national digital expertise. This includes clearer responsibilities for partners, closer working with HEIW on digital skills, and providing more structured feedback to DHCW and the Welsh Government on national programmes and initiatives.

Evaluating digital solutions

44 The Trust does not yet have a clear or consistent approach to reviewing projects after delivery or checking if the expected benefits have been achieved. There is no dedicated evaluation function, and benefits such as improved efficiency, productivity, or patient experience are often described rather than measured.

45 The lack of regular post-implementation reviews makes it hard to learn from experience, understand the impact of digital projects, and show whether investment is delivering value. As a result, while digital systems are being delivered and used, the Board does not receive clear assurance that they are delivering sustained improvements.

Recommendations

47 The following table details the recommendations arising from our work.

R1	The Trust should strengthen its Digital Plan by:
1.1	outlining its current level of digital maturity and the measures it will use to track maturity and success over time. (**Paragraph 12**)
1.2	setting clear milestones, details of ownership, and resource needs. (**Paragraph 13**)
R2	The Trust should improve digital reporting by:
2.1	including clear milestones, measures of progress and outcome, risk updates and more consistent information across programmes. (**Paragraph 17**)
2.2	using plain language and explaining technical terms, so reports are easy to understand and support effective challenge. (**Paragraph 18**)
R3	The Trust should strengthen its Board Assurance Framework by clearly identifying and describing risks to digital transformation, including delivery, capacity, and resource related risks. (**Paragraph 21**)

R4 The Trust should develop a clear, costed digital infrastructure replacement plan with timelines, milestones, asset information, and long-term investment needs. This should be supported by clearer reporting on how effectively infrastructure risks are being managed. (**Paragraph 23**)

R5 The Trust should develop a clear AI strategy and governance framework. This should set out how AI will be used across the organisation, the expected benefits, how success will be measured, and how risks will be managed. (**Paragraph 27**)

R6 The Trust should develop a structured approach to understanding and building its digital workforce capability by:

6.1 maximising use of HEIW's Digital Capability Framework to assess basic digital confidence. (**Paragraph 29**)

6.2 developing a local assessment of the wider digital skills needed to deliver the Trust's digital ambitions. (**Paragraph 29**)

6.3 developing a targeted, role-specific training and learning programme beyond basic e-learning, including data and digital change skills. (**Paragraph 30 and 31**)

6.4 developing a strategic digital workforce plan that sets out required staffing levels, roles, competencies and future capacity needs, informed by a clear baseline of current digital workforce capability. (**Paragraph 32**)

R7 The Trust should develop a clear approach to engagement and digital inclusion by:

7.1 introducing a framework to involve staff and service users in digital design and delivery. (**Paragraph 33**)

7.2 developing a digital inclusion plan with clear priorities, actions, measures, and risk management arrangements. (**Paragraph 35**)

7.3 improving Board reporting on engagement and digital inclusion activity and impact. (**Paragraph 35**)

R8 The Trust should set out clear, costed investment plans for digital transformation, including capital and revenue needs beyond 2025-26. (**Paragraph 36**)

R9 The Trust should introduce a consistent post-implementation review process to assess whether digital investments deliver benefits, value for money, and better use of resources. (**Paragraph 45**)

Appendices

1 About our work

Scope of the audit

The goal of this audit is to find out if the Trust is using digital technology to support service modernisation and efficiency. This included the approach to strategy, leadership and skills development for digital transformation, and how risks around digital infrastructure, cyber resilience and artificial intelligence are being managed.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Trust have a well-led and appropriately resourced approach to digital transformation?
- Is the Trust developing the digital skills, capacity, and capability of its workforce?
- Does the Trust have a clear plan for managing its cyber resilience arrangements and digital infrastructure and how they will need to change to support its digital transformation ambitions?
- Does the Trust engage effectively with staff, partners, patients / service users to deliver its digital transformation ambitions and minimise digital exclusion risks?
- Is the Trust actively utilising new digital technology and data solutions to enhance the accessibility, quality, efficiency, and productivity of its services?

Criteria

Our audit questions were shaped by:

- External reference input from the Welsh Government, all-Wales NHS Directors of Digital, and Digital Health & Care Wales.

- Relevant Welsh Government strategies and plans.
- Relevant NHS Digital Transformation review reports completed by the National Audit Office and House of Commons Health and Social Care Committee.
- NHS England Department of Health & Social Care: A plan for digital health and social care policy paper.
- NHS England Transformation Directorate: What good looks like framework.

Methods

We asked the Trust to:

- Complete a self-assessment to help us understand how the organisation is undertaking digital transformation.
- Give us facts and figures about its spending on digital technology, staff digital skills, cyber resilience, and how it involves people in digital transformation.

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Finance and Performance Committee reports and Board papers.
- Key strategies and plans, including the Digital Plan, IMTP 2025-28 and Annual Plan.
- Key risk management documents, including the BAF.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Director of Digital Services.
- Interim Chief Executive.
- Assistant Director of Finance.

We observed Board meetings as well as meetings of the Finance and Performance Committee.

2 Key terms in this report

Term	Description
Digital Plan ('Our Digital Plan')	The Trust's strategy for digital.
Integrated Medium-Term Plan (IMTP)	An IMTP is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to the Welsh Government for approval.
Digital and Data Roadmap	The programme of digital priorities within the IMTP.
Digital maturity	The organisation's capability to use digital effectively, often assessed against a framework.
Health Information and Management Systems Society (HIMSS)	The HIMSS is a global non-profit organisation dedicated to improving health through the best use of information technology and management systems.
Electronic Medical Record Adoption Model (EMRAM) Assessment	The EMRAM is a strategic, eight-stage (0–7) framework developed by HIMSS to measure, benchmark, and improve a hospital's digital maturity. It guides organizations from paper-based systems to a fully electronic, paperless environment, aiming to enhance patient safety, clinical outcomes, and efficiency.

Term	Description
Board Assurance Framework (BAF)	A BAF in the NHS is a structured, strategic tool used by boards to monitor risks that threaten the achievement of corporate objectives.
Network and Information Systems (NIS) Regulations 2018	The NIS Regulations 2018 aim to improve the cybersecurity and resilience of systems that provide essential services.
Artificial Intelligence (AI)	AI is the ability of machines, computer systems, or robots to mimic human intelligence, learning, and decision-making to perform specific tasks.
HEIW's Digital Capability Framework	A national model outlining the digital skills, behaviours and confidence health and care staff need, organised into six capability domains with a self-assessment tool for development.
User engagement	Involving staff, patients and service users in digital design and delivery.
Digital skills baseline	An assessment of current digital capability across the workforce.
Digital inclusion	Ensuring digital services are accessible to people with different needs and abilities.
Digital exclusion	Barriers that prevent people from accessing or using digital services.
NHS 111	The national non-emergency health advice service.
Electronic Patient Care Record (ePCR)	The digital record used by ambulance clinicians.

Term	Description
Dispatch and control room systems	Systems used to manage emergency response and deployment.
Cloud-based systems	Digital systems hosted online rather than on local servers.
Once For Wales	National approach in NHS Wales where a digital system, process or standard is designed, procured and implemented once at a national level, rather than each health board creating its own version.
Post-implementation review (PIR)	A review to assess whether a project delivered its intended benefits.

About us

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

Management response form

Audit Wales use only	
Audited body	Welsh Ambulance Services University NHS Trust
Audit name	Digital Transformation
Issue date	June 2026

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Trust should strengthen its Digital Plan by:			
R1.1	outlining its current level of digital maturity and the measures it will use to track maturity and success over time. (Paragraph 12)	The Trust accepts this recommendation. As part of the ongoing refresh of the Digital Plan, a formal digital maturity baseline will be established using recognised maturity frameworks, alongside locally agreed measures. The Trust will assess the most appropriate framework and benchmarking approach for its operational context,	March 2027	Director of Digital Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		recognising its unique position as the only ambulance trust within NHS Wales. This will include consideration of relevant peer benchmarking beyond Wales, where appropriate, alongside national NHS Wales comparators and longitudinal assessment of the Trust's own maturity over time. This approach will provide a consistent means of assessing progress, identifying areas for improvement and demonstrating advancement against strategic outcomes rather than technology implementation alone.		
R1.2	setting clear milestones, details of ownership, and resource needs. (Paragraph 13)	The Trust agrees that future iterations of the Digital Plan should provide greater clarity around ownership, milestones and resource assumptions. This work will be delivered through the development of the Trust's new Digital, Data and Technology (DDaT) governance framework and Digital Oversight Group (DOG), which will provide strengthened governance, clearer accountability, delivery milestones and oversight arrangements across the digital portfolio.	March 2027	Director of Digital Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R2	The Trust should improve digital reporting by:			
R2.1	including clear milestones, measures of progress and outcome, risk updates and more consistent information across programmes. (Paragraph 17)	The Trust accepts this recommendation. Work is already underway following the recent Good Governance Institute review to strengthen digital governance and assurance arrangements. Standardised reporting templates will be introduced to provide clearer milestones, delivery status, benefits, strategic alignment, key risks and outcome measures across all major digital programmes.	March 2027	Director of Digital Services
R2.2	using plain language and explaining technical terms, so reports are easy to understand and support effective challenge. (Paragraph 18)	The Trust agrees. Future Board reporting will place greater emphasis on strategic outcomes using plain English, supported by concise explanations of technical terminology where appropriate. Reporting will focus on enabling effective Board scrutiny rather than technical delivery updates alone.	December 2026	Director of Digital Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R3	The Trust should strengthen its Board Assurance Framework by clearly identifying and describing risks to digital transformation, including delivery, capacity, and resource related risks. (Paragraph 21)	The Trust accepts this recommendation. As part of the wider review of corporate governance following the Good Governance Institute review, the Board Assurance Framework will be updated to include a dedicated strategic risk relating to digital transformation. This will better reflect risks associated with programme delivery, workforce capacity, dependency management, affordability and organisational change.	December 2026	Director of Digital Services
R4	The Trust should develop a clear, costed digital infrastructure replacement plan with timelines, milestones, asset information, and long-term investment needs. This should be supported by clearer reporting on how effectively infrastructure risks are being managed. (Paragraph 23)	The Trust agrees that a more strategic view of infrastructure investment would strengthen assurance. Existing lifecycle information, cyber risk assessments and infrastructure roadmaps will be consolidated into a longer-term infrastructure replacement plan identifying asset lifecycles, prioritised replacement requirements and estimated investment needs. However, the Trust notes that NHS Wales financial planning operates on an annual planning cycle, with future capital allocations confirmed annually. Whilst a longer-term costed replacement plan will improve strategic planning and prioritisation, it cannot	June 2027	Assistant Director of Digital: ICT

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		provide assurance that identified investment requirements beyond approved funding periods will be deliverable until funding allocations are confirmed.		
R5	The Trust should develop a clear AI strategy and governance framework. This should set out how AI will be used across the organisation, the expected benefits, how success will be measured, and how risks will be managed. (Paragraph 27)	The Trust accepts this recommendation. An AI Strategy and Governance Framework is already in development and is planned for implementation during the current financial year. This will build upon the existing AI Steering Group and Board oversight arrangements, setting out priority use cases, governance, ethical principles, benefits realisation and risk management aligned to emerging national guidance for NHS Wales.	June 2027	Assistant Director of Digital: IDS
R6	The Trust should develop a structured approach to understanding and building its digital workforce capability by:			

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R6.1	maximising use of HEIW's Digital Capability Framework to assess basic digital confidence. (Paragraph 29)	The Trust accepts this recommendation. Greater promotion of the HEIW Digital Capability Framework will form part of the wider workforce development programme to improve understanding of baseline digital confidence across the organisation.	June 2027	Assistant Director of Digital: IDS
R6.2	developing a local assessment of the wider digital skills needed to deliver the Trust's digital ambitions. (Paragraph 29)	The Trust agrees with the principle of this recommendation. The Trust recognises the need to strengthen its approach to developing a digitally skilled workforce and has already begun taking tangible steps to address the gaps identified. The recent recruitment of a Head of Business Change and Benefits, alongside the appointment of a Digital Adoption Facilitator, provides dedicated leadership to establish a more structured and outcome-driven approach. Together, these roles will lead the development of a benefits realisation framework for digital projects, ensuring that digital investment translates into measurable improvements in capability and service delivery.	June 2027	Assistant Director of Digital Services: Innovation & Transformation

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		This work will be supported by a stronger focus on user-centred design, with staff actively involved in co-designing new systems to ensure solutions are intuitive and aligned to operational needs. In addition, the establishment of a Digital Champions network will create localised support and peer-led learning opportunities, helping to embed digital skills across the workforce and improve adoption of new technologies. These initiatives represent a shift towards a more coordinated and sustainable model for digital skills development, including clearer approaches to skills assessment, gap identification, targeted training, and measurement of impact.		
R6.3	developing a targeted, role-specific training and learning programme beyond basic e-learning, including data and	The Trust accepts this recommendation. A structured digital learning and capability programme will be developed bringing together existing training, digital change capability, data literacy, AI awareness and leadership development into a coherent programme aligned to role requirements.	June 2028	Director of People & Culture / Director of Digital Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	digital change skills. (Paragraph 30 and 31)	This recognises that previous investment priorities have necessarily focused on maintaining critical operational services rather than broader organisational capability development.		
R6.4	developing a strategic digital workforce plan that sets out required staffing levels, roles, competencies and future capacity needs, informed by a clear baseline of current digital workforce capability. (Paragraph 32)	The Trust agrees. A Digital Workforce Plan will be developed which establishes the current workforce baseline, future capability requirements and anticipated capacity needed to support delivery of the Digital Plan over the medium term.	September 2027	Director of Digital Services
R7	The Trust should develop a clear approach to engagement and digital inclusion by:			

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R7.1	introducing a framework to involve staff and service users in digital design and delivery. (Paragraph 33)	The Trust accepts this recommendation. The Trust's Innovation Lab, currently in development and planned to launch during the current financial year, will provide a structured mechanism for engaging staff, patients and service users in the design, testing and evaluation of digital services. This will form the foundation of a broader engagement framework supporting co-design across future digital transformation programmes.	March 2027	Head of Digital Benefits
R7.2	developing a digital inclusion plan with clear priorities, actions, measures, and risk management arrangements. (Paragraph 35)	The Trust agrees. A Digital Inclusion Plan will be developed, building upon existing commitments within the Digital Plan. This will identify key priorities, ownership, measures of success and governance arrangements whilst aligning with wider equality and inclusion strategies across the Trust.	June 2027	Director of Digital Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R7.3	improving Board reporting on engagement and digital inclusion activity and impact. (Paragraph 35)	The Trust agrees. The development of the new DDaT governance framework and Digital Oversight Group (DOG) will strengthen reporting arrangements for engagement and digital inclusion. The DDaT governance group will be responsible for reviewing agreed performance measures and KPIs, ensuring regular reporting of engagement activity, digital inclusion outcomes and the impact of user feedback to support Board assurance.	June 2027	Director of Digital Services
R8	The Trust should set out clear, costed investment plans for digital transformation, including capital and revenue needs beyond 2025-26. (Paragraph 36)	The Trust partially accepts this recommendation. The Trust will continue to strengthen the financial planning underpinning the Digital Plan by developing indicative multi-year investment profiles aligned to organisational priorities and infrastructure lifecycle requirements. However, recognising the NHS Wales financial planning environment, detailed costed investment plans beyond confirmed funding periods will necessarily remain indicative and subject to annual IMTP approval, capital allocations and national funding decisions.	June 2027	Director of Digital Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R9	The Trust should introduce a consistent post-implementation review process to assess whether digital investments deliver benefits, value for money, and better use of resources. (Paragraph 45)	The Trust accepts this recommendation. Since completion of this audit, the Trust has appointed a Head of Business Change and Benefits whose role includes establishing a consistent benefits realisation and post-implementation review framework across the digital portfolio. This work has commenced and will be embedded within the emerging DDaT governance arrangements, providing clearer oversight of benefits, lessons learned and value for money across major digital investments.	March 2027	Head of Digital change and benefits

Internal Audit Progress Report

Audit, Risk and Assurance Committee

September 2026

Welsh Ambulance Services University NHS Trust

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

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Appendix A: Progress against 2026/27 Internal Audit Plan *7*

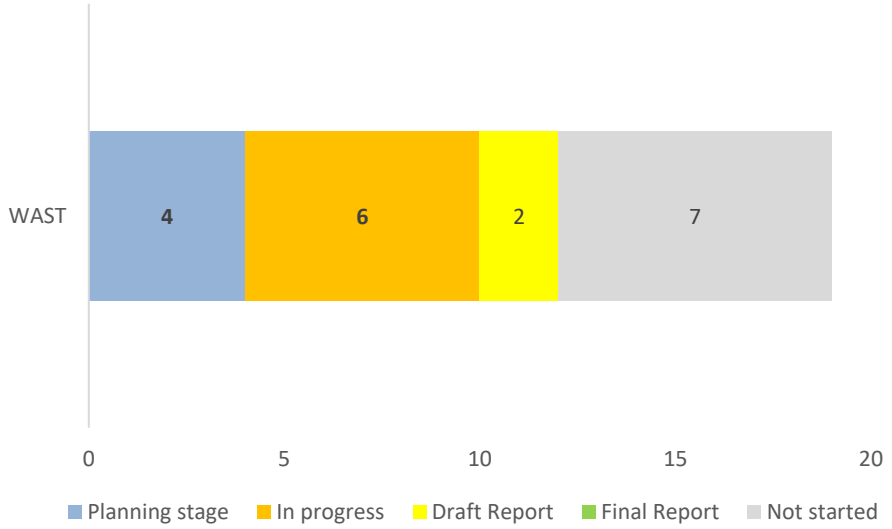
1. Introduction

The purpose of this report is to:

- highlight progress of the 2026/27 Internal Audit Plan to the Audit, Risk and Assurance Committee; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2026/27 Internal Audit Plan

There are 19 reviews in the 2026/27 Internal Audit Plan, and overall progress is shown below.



Detailed progress in respect of each of the reviews in the 2026/27 Internal Audit Plan is summarised in Appendix A.

3. Proposed changes to the approved plan

No changes are proposed to the 2026/27 Internal Audit Plan.

4. Follow Up of Internal Audit Recommendations

In accordance with the follow-up approach introduced within the 2025/26 Internal Audit plan year, a minimum of 50% of high-priority recommendations and 10% of medium-priority recommendations arising from internal audit reports issued during 2025/26 will be subject to follow-up review throughout the year. Recommendations selected for review will be drawn from those recorded as closed within the Trust's recommendation tracker.

Our initial review was undertaken in two tranches:

1. Recommendations with an expected implementation date on or before 31 March 2026; and
2. Recommendations with an expected implementation date on or before 31 May 2026, aligning with the Quarter 1 update provided by the Head of Compliance & Assurance.

Of the 81 recommendations issued in 2025/26:

- 10 recommendations (12.5% - including two high and eight medium priority recommendations) had an original target implementation date of 31 March 2026 or earlier. Of these, three (30%) had been recorded as closed. The remaining seven recommendations had revised target dates recorded on the tracker, all within Quarter 2 of 2026/27.
- A further five recommendations (6.4% - all medium priority recommendations) had an original target implementation date between 1 April and 31 May 2026. Of these, one recommendation (20%) had been recorded as closed. Of the remaining four recommendations, three had revised target implementation dates recorded on the tracker: one in Quarter 3 of 2026/27; one in Quarter 4 of 2026/27 and one in Quarter 1 of 2027/28. One recommendation (Risk Management, Key Finding 1, medium priority) had not yet been assigned a revised target implementation date.

Review of the recommendation tracker identified that, in addition to the recommendation due by 31 May that had been closed, a further three medium priority recommendations had also been recorded as closed by that date. Welsh Language Standards (Key Finding 2) and Job Evaluation (Key Finding 1) were closed ahead of their original target implementation dates of June 2026. Clinical Equipment (Key Finding 4), which had been reported as one of the seven overdue recommendations at 31 March 2026, had subsequently been implemented and closed following revision of its target implementation date.

Given the low level of closure, which was broadly in line with the low number of recommendations expected to be implemented at this stage of the year, no sample testing has been undertaken at this time.

Our next review will consider recommendations with an expected implementation date between 1 June and 30 September 2026, aligning with the Quarter 2 update provided by the Head of Compliance & Assurance. This will include 21 recommendations expected to be implemented by that date, comprising 15 recommendations with original target implementation dates between June and September 2026 (noting that two recommendations have already been closed ahead of their original target dates) and six overdue recommendations from the current review with revised implementation dates in Quarter 2 2026/27. Our conclusions will be reported to the December Audit, Risk and Assurance Committee.

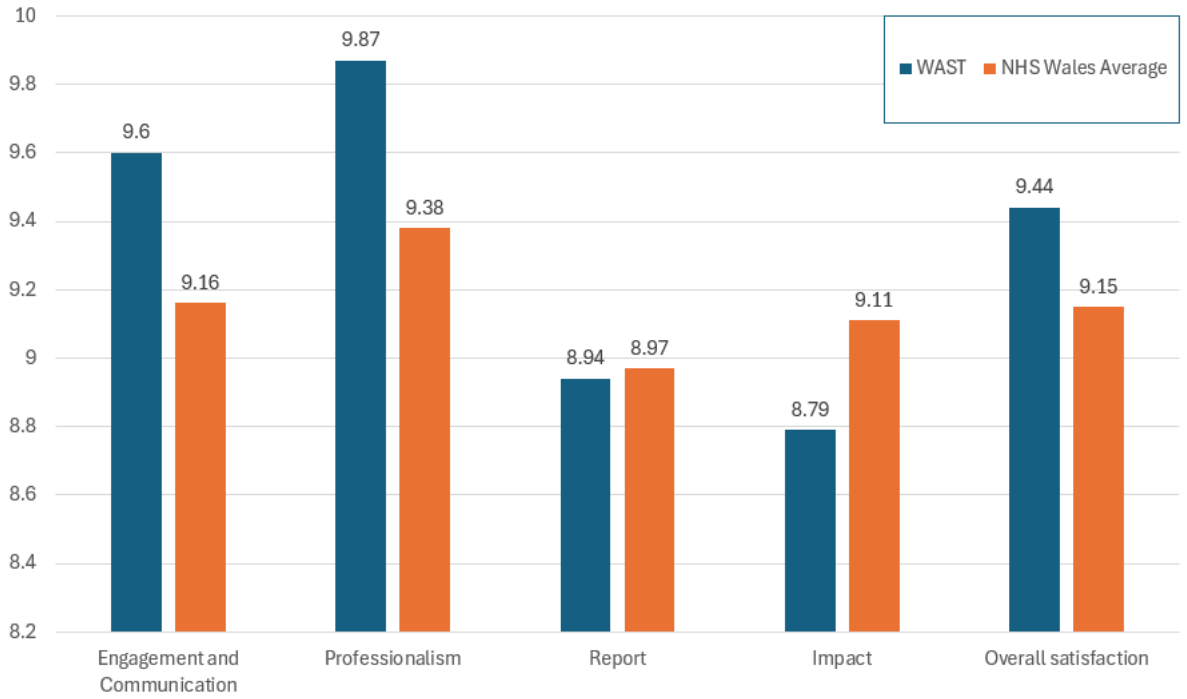
5. Engagement

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

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

6. Post Audit Questionnaire (PAQ) Feedback – 2025/26

The use of Microsoft Forms has sustained improved engagement with the PAQ process. During 2025/26, the Trust achieved a 63% response rate, closely aligned with the national average of 65%. Satisfaction scores continued to be very positive across all categories and were broadly in line with national averages and the previous year.



Qualitative feedback remained positive, with recurring themes of professionalism, effective communication and supportive audit delivery.

7. Key Performance Indicators

Correct on 30 July 2026

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2026/27	●	March	By 30 June
Audits reported over planned	N/A	0	0
Work in progress		6	
Report turnaround: time from fieldwork completion to draft reporting [10 days]	N/A	0 out of 0	80%
Report turnaround: time taken for management response to draft report [15 days]	N/A	0 out of 0	80%
Report turnaround: time from management response to issue of final report [10 days]	N/A	0 out of 0	80%

Key:

- ● v>20%
- ● 10%<v<20%
- ● v<10%

8. Recommendation

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

Appendix A: Progress against 2026/27 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Risk Management and Board Assurance	Not started			April / June 2027
Follow Up of Internal Audit Recommendations	In progress	See section 4. A sample of closed recommendations will be validated on a rolling basis, with updates provided at each Audit, Risk and Assurance Committee meeting and a summary report prepared at year-end to capture the overall status.		June 2027
Savings Planning and Monitoring Arrangements	Not started			March / April 2027
Integrated Medium-Term Plan Delivery	Not started			March / April 2027
Commercial Development and Income Generation (Advisory)	In progress			December 2026
Family Complaints – Putting Things Right and Legal Services Recovery Plan	Not started			March / April 2027
Medical Examiner System and Mortality Reviews	Draft report			December 2026
Clinical Navigator Role – Effectiveness and Integration	Not started			March 2027
Operations Directorate Structure and Governance Arrangements	In progress			December 2026
Shift Overruns	In progress			December 2026
Time Off in Lieu	Planning			March / April 2027
Medical Gases	In progress			December 2026
Cyber Security	Draft report			December 2026
Shadow IT	Planning			March 2027

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Service Management	Planning			April / June 2027
Secondary Employment: Disclosure and Control Arrangements	In progress			December 2026
Anti-Sexual Harassment Policy and Implementation Plan	Not started			June 2027
Stress Management	Not started			March / April 2027
Estates Assurance: Control of Contractors	Planning			March / April 2027

[1] May be subject to change

Emerging Technology Adoption

Final Internal Audit Report

Welsh Ambulance Service University NHS Trust

Reasonable Assurance

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Review Reference	WAS-2526-14
Fieldwork	January 2026 - June 2026
Executive Sign Off	18 June 2026
Audit Committee	September 2026
Executive Lead	Jonny Summat, Director of Digital
Audit Team	Osian Lloyd, Head of Internal Audit
	Martyn Lewis, IT Audit Manger

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To assess the robustness of the processes in place to ensure the effective, safe, and well-governed use of new and emerging technologies, such as Artificial Intelligence (AI) and automation.

Overview

New and emerging technology such as AI and automation, offer significant opportunities to improve service delivery through increased efficiency and enhanced use of data. The Trusts Digital Plan (2024-2029) contains a key theme of "Digital Pioneers", which is dedicated to driving innovation and embracing these technologies to enhance services. This ambition is reflected within the Trust's Integrated Medium-Term Plan.

We have concluded **reasonable assurance** on this area. The Trust is at the early stage in its adoption of AI and automation, with a clear strategic intent to expand the use of these technologies. While a number of areas require further development, particularly in relation to the formalisation, consistency, and scalability of governance frameworks, there is evidence that core controls are in place and operating. This includes emerging governance structures, controlled access to AI tools, established processes for automation development, and active oversight through relevant groups.

Current use of AI and automation remains relatively limited and is being managed proportionately. As such, the control environment is considered adequate for the current level of activity. However, the findings within this report highlight that further strengthening is required to ensure that governance, resourcing, and control frameworks are sufficiently mature to support the Trust's planned expansion of AI and automation. In particular, greater formalisation of policies, procedures, prioritisation frameworks, and documentation standards will be necessary to ensure risks continue to be effectively managed as usage increases..

The key matters requiring management attention, primarily relating to the formalisation and scalability of controls, are set out below:

- At present, there is limited dedicated resource to support the development and use of AI or automation. No formally established team exists, with only one developer supporting automation and limited capacity to develop AI capabilities.
- The AI Policy has not yet been formally approved or issued. While interim guidance is in place, this is limited in scope and does not fully address key risks or acceptable use. Until formal governance processes are approved, communicated and embedded, there is a risk that staff may use AI tools without appropriate assessment and approval.
- There are no standard operating procedures in place for developing automated processes, and no formal guidance is available for the wider organisation.
- There is no formal prioritisation framework for automation requests. While decisions are made in practice, the absence of documented criteria reduces transparency and clarity over how resources are targeted and aligned to organisational priorities.
- There are no standard templates for documenting the design of automated processes. While current documentation captures some key elements, it does not fully document process logic, data flows, user approval of design and testing, or formal approval prior to deployment.
- Although departments are advised to maintain continuity arrangements for automated processes, there is no formal requirement to document these arrangements before an automation goes live.
- The register of automated processes includes details of target systems and required permissions, supporting visibility of dependencies. However, this information is not consistently completed, and in the absence of detailed design documentation, this limits the Trust's ability to fully identify and manage dependencies between automated processes and the wider technical environment.

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

- Defining expected run times during testing and incorporating automated timeouts within process flows would reduce the risk of automation failures adversely impacting operations.

Scope & Assurance Summary

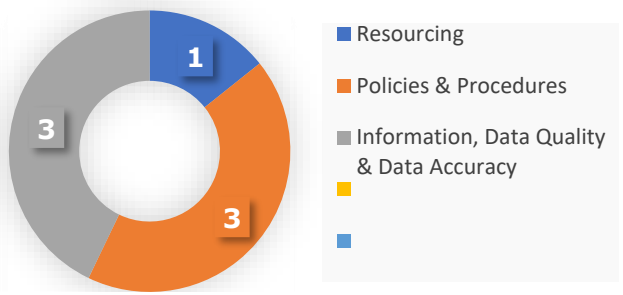
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The use of evolving technology is included within organisation plans, with appropriate resources available to develop their use.	1	**Reasonable**
2	Appropriate controls and guidance are in place for the use of technology which protects information, accounts, and ensures that models are accurate, free from bias and protect information.	2, 3	**Limited**
3	An appropriate process is in place to control the creation of automated processes and the resource use, with an assessment process to ensure only suitable processes are automated and benefits are defined and realised.	4	**Reasonable**
4	Appropriate processes are in place to fully document the design of automated process and test the final product with the operation of new technology monitored to ensure they operate as expected.	5	**Reasonable**
5	An appropriate process is in place to ensure that changes to the environment in which automated processes operate are assessed for the impact, changes to automated processes are recorded and appropriate continuity planning is in place to enable the organisation to operate in the event of the failure of the technology.	6, 7	**Reasonable**

Management Actions

2 High Priority

5 Medium Priority

Themes



Risk Types

Public Perception & Reputational Risk

Legal & Regulatory Non-Compliance

Choose an item.

Choose an item.

Findings & Agreed Action Plan

Objective 1: The use of evolving technology is included within organisation plans, with appropriate resources available to develop their use.	**Reasonable**

The Trust has developed a Digital Plan covering the period 2024-2029. A key component of the Plan is the 'Digital Pioneers' pillar, which focuses on the adoption and integration of emerging technologies to improve service efficiency, effectiveness, and quality. The Plan promotes a culture of continuous improvement, experimentation and innovation to ensure that services evolve in-line with patient and community needs.

The Digital Plan includes key initiatives including Artificial Intelligence (AI); Use of drones; Virtual and augmented reality; and Chatbot and self-service automation. These initiatives are reflected within Digital Local Delivery Plan and subject to ongoing monitoring.

Delivery of the Digital Plan is supported by the IMTP 2025-28, with Section 7 setting out the Trust's 'Digital & Data Roadmap', aligned to Strategic objective 3: '*Being at the forefront of innovation and technology.'* The roadmap outlines similar priorities to the Digital Plan, including a dedicated Digital Pioneers focus.

The IMTP states that automation and workplace efficiency will be progressed through Digital Pioneers projects and pilot initiatives. A central proposed enabler will be the establishment of a digital innovation lab, intended to support idea generation, feasibility assessment, and prioritisation of technology proposals from across the organisation.

The use of AI and Automation is also included within the business case proposal for the 111 Digital Front End, further demonstrating the Trust's commitment to leveraging new technologies to enhance service delivery.

However, at present, there is limited dedicated resourcing to support the development and implementation of AI or automation. There is no formally established team responsible for this area, and only one developer is in place to support automation, resulting in limited capacity to develop AI capabilities (see **Key Finding 1**). While discussions indicate that consideration is being given to the appointment of an automation manager, this role has not yet been established.

Key Findings		Risk & Impact	Agreed Management Action
1	**Resourcing for AI and Automation Delivery** At present, there is limited dedicated resource to support the development and use of AI or automation. No formally established team is in place, with only one developer supporting automation and limited capacity to progress AI capabilities.	The Trust may not be able to deliver the objectives as set out within the IMTP and Digital Plan, limiting the realisation of anticipated benefits and innovation.	**Agreed Action:** The Trust has already invested in dedicated automation capability through the recruitment of a Low Code and Automation Developer to support the development and adoption of automation technologies across the organisation. Whilst a dedicated AI and Automation function is not currently established, automation and AI initiatives continue to be progressed through existing Digital Directorate resources, governance arrangements, and programme delivery structures. Management acknowledges that demand for automation and AI capabilities is increasing and that there is a need to ensure available resources are aligned to organisational priorities. However, the Trust considers that future resourcing requirements should be informed by evidenced demand,

			strategic priorities, and delivery capacity rather than predetermined organisational structures. To support this, the Trust is establishing a Digital Oversight Group (DOG) to provide formal governance, prioritisation, and oversight of digital innovation, automation, and AI initiatives. This will provide improved visibility of organisational demand, anticipated benefits, resource requirements, and delivery capacity, enabling informed decisions regarding future operating model and resourcing requirements. The Trust will utilise the Digital Oversight Group to establish a prioritised pipeline of automation and AI initiatives, assess organisational demand, and review delivery capacity against strategic objectives. This will inform future decisions regarding the operating model, governance arrangements, and any additional resource requirements necessary to support sustainable delivery.
			Expected Evidence of Implementation • Approved Terms of Reference for the Digital Oversight Group • Prioritised pipeline of automation and AI initiatives • Evidence of governance oversight and prioritisation decisions • Review of automation and AI demand, capacity, and resource requirements through established governance processes
		High Priority	**Officer:** Wyn Morris, ICT Service Desk Manager **Target Implementation Date:** 31st December 2026
	Theme: Resourcing	Control Design	

Objective 2: Appropriate controls and guidance are in place for the use of technology which protects information, accounts, and ensures that models are accurate, free from bias and protect information.	**Limited**

There is currently limited formal guidance available to support the safe and appropriate use of AI within the Trust. The Trust does not currently have an approved AI Policy in place. While discussions have taken place with Digital Health & Care Wales (DHCW) regarding the adoption of an All-Wales AI policy, the Trust has concluded that the proposed national approach would not be suitable for its specific operational needs. Our review of other NHS Wales organisations identified that, at present, only Velindre NHS Trust has an approved AI policy in place.

The Trust is in the process of developing its own AI policy. The most recent draft (dated November 2025) was supplied to us; however this has not yet progressed through the Trust's formal approval process. In the absence of a formal policy, interim digital guidance was issued in January 2025 on the general use of AI for work, and in April 2025 to support the safe use of Microsoft Copilot. While these provide staff with some direction, the guidance is limited in scope and does not fully address wider AI-related risks, including data protection, bias, model accuracy, and acceptable use. It does not set out a clear mechanism for staff to assess, approve, and monitor the use of AI tools (see **Key Finding 2**).

Uncontrolled or unguided use of AI increases the risk of data leakage and reliance on inappropriate or inaccurate models. The Trust has acknowledged this risk, reflected by the inclusion of AI-related risks within the risk register, with oversight provided through the Information Governance Steering Group.

At present, AI usage within the Trust is limited. An AI Steering Group has been established to monitor, guide and provide oversight over the use of AI tools. Our review identified that the group maintains a log of AI implementations and use cases and monitors the AI related deliverables within the IMTP. In the absence of a formal governance framework, the group is trialling the use of a structured decision-making and problem-solving approach to assess AI proposals against seven pillars of responsible AI use.

The use of copilot is controlled, with a formal request and approval process in place. Requests for access are recorded and assessed prior to approval. Monitoring arrangements are also in place through Microsoft Purview, and firewall controls enable tracking of access to public AI, with high-risk sites restricted.

The development of automation is restricted to digital staff. While each development is subject to a Data Protection Impact Assessment (DPIA), there is limited formal guidance on the design and development of automation solutions. There are no standard operating procedures (SOPs), standard templates for documenting automated processes, or defined governance requirements. While the current restricted use enables visibility and direct management of automation, this approach is unlikely to remain sustainable as automation adoption increases across the Trust (see **Key Finding 3**).

Key Findings		Risk & Impact	Agreed Management Action
2	**AI Policy and Governance Framework** The AI Policy has not yet been approved or implemented. Interim guidance is in place but does not comprehensively address AI risks or define acceptable use. There is no formal mechanism for staff to assess, approve or govern the use AI products.	Increased risk of data leakage and the use of inappropriate, biased or inaccurate AI models, potentially leading to regulatory, reputational, or operational impacts.	**Agreed Action:** The Trust will finalise, approve, and implement the Artificial Intelligence (AI) Policy and supporting governance framework, building upon the controls and governance arrangements already established through the Artificial Intelligence Steering Group (AISG) and wider Information Governance structures. This will include:

			• Formal approval and publication of the AI Policy • Communication and awareness activity to support staff understanding of AI risks, responsibilities, and acceptable use • Establishment of a standardised process for the assessment, review, and approval of AI technologies and use cases • Definition of roles, responsibilities, and governance arrangements for AI oversight • Integration of AI-related risks and assurance activities within existing governance and risk management processes • Development of supporting guidance, standards, and implementation materials to support the safe, ethical, and compliant use of AI technologies across the organisation These arrangements will ensure that AI technologies are subject to appropriate governance, risk assessment, oversight, and assurance prior to implementation and throughout their operational lifecycle.
			Expected Evidence of Implementation: - Approved AI Policy. - Evidence of communication and staff awareness. - Established governance and approval processes.
		High Priority	**Officer:** Leanne Smith, Assistant Director of Digital Services: Data & Analytics
	Theme: Policies & Procedures	Control Design	**Target Implementation Date:** 31st December 2026
3	**Automation Development Standards and Guidance** There are no SOPs, standard templates or formal guidance for the development of automated processes. Currently controls rely on restricted access rather than formalised governance.	Automated processes may be inconsistently designed, increasing the risk of operational failure, control weaknesses, or non-compliance with governance and data protection requirements.	**Agreed Action:** The Trust recognises the value of establishing a more formal and consistent approach to automation governance as the use of automation technologies continues to expand across the organisation. Whilst a range of governance and assurance activities are already undertaken as part of automation delivery, including design documentation, testing and validation, DPIA assessment, information governance review, and stakeholder engagement, these processes have evolved over time and

			are not currently supported by a single, standardised framework, set of templates, or documented procedures. To support the continued growth of automation and digital innovation activity, the Trust is currently developing a standardised automation intake and governance solution. This will provide a consistent mechanism for the submission, assessment, prioritisation, approval, and documentation of automation opportunities, whilst ensuring appropriate governance, security, and information governance considerations are incorporated throughout the lifecycle. This work will support the introduction of standard operating procedures, templates, documentation standards, and approval processes, providing a clear and proportionate governance framework for future automation activity. The Trust will implement a standardised automation governance framework through the development of the automation intake and governance solution. This will include: • Standard operating procedures and guidance documentation • Standard templates and documentation requirements • Defined approval, security, and information governance requirements • Consistent assessment and governance processes for automation requests • Alignment with Digital Oversight Group governance arrangements
			Expected Evidence of Implementation: • Approved SOPs and supporting templates • Standardised automation intake and governance process • Evidence of consistent documentation for new automation initiatives • Defined and implemented approval processes • Governance records demonstrating oversight and decision-making
		Medium Priority	**Officer:** Kara Walsh, ICT Service Desk Manager **Target Implementation Date:** 31st December 2026
	Theme: Policies & Procedures	Control Design	

Objective 3: An appropriate process is in place to control the creation of automated processes and the resource use, with an assessment process to ensure only suitable processes are automated and benefits are defined and realised	**Reasonable**

Automation capability within the Trust is delivered by Blue Prism and Power Automate (PA). However, use of Blue Prism has been limited in recent years, with no new developments undertaken, despite ongoing licensing costs.

The Trust maintains an inventory of automated processes currently in operation. Development of Power Automate solutions is restricted to the Digital Services directorate, while Blue Prism automations are provided by an external contractor due to limited in-house capacity. Requests for automation are submitted to Digital Services, and a significant number of potential automation opportunities has been identified across the Trust. However, due to current resource constraints, only a subset of requests can be progressed. A backlog has developed which, at current capacity, is projected to take until November next year to clear.

The automation request process includes submission of a standard form, capturing key information including the process to be automated and the current resource requirements (staff time and effort). This provides a documented baseline against which potential and realised benefits can be assessed.

Assessment of automation requests is undertaken by Digital Services staff based on professional knowledge and experience. However, there are no formal procedures or documented criteria which would set out the basis for prioritisation. In practice, priority is given to requests from senior management, higher-risk areas. and those expected to deliver significant value. While this approach provides some direction, it lacks transparency and consistency, limiting assurance that resources are being optimally allocated to maximise organisational benefit (see **Key Finding 4**).

We note that a Digital Oversight Group is in the process of being established, with one of its intended roles being to ensure digital initiatives, including automation, are prioritised appropriately. Once operational, this should improve clarity and formalisation of prioritisation processes, including a potential introduction of a structured assessment and scoring methodology.

The current request process captures key information on the "as is" process, rationale for automation, and baseline resource usage (including time and effort). This enables the Trust to assess relative value, target automation effort effectively, and demonstrate realised benefits. Some tracking of realised benefits is in place, particularly from the Blue Prism automations, and these are being formally reported.

Key Findings		Risk & Impact	Agreed Management Action
4	**Prioritisation and Governance of Automation Requests** There are no formal procedures or documented criteria in place which set out the basis for prioritisation of automation requests, resulting in limited transparency over how decisions are made and how resources are targeted to maximise organisational value.	The Trust may not direct limited automation capacity towards the highest-value or highest-risk processes, reducing overall efficiency gains	**Agreed Action:** The Trust recognises the importance of ensuring automation opportunities are assessed, prioritised, and governed in a consistent and transparent manner to maximise organisational benefit and ensure available resources are directed towards the highest value activities. Whilst automation requests are currently reviewed through existing Digital governance and operational processes, the Trust acknowledges that there is an opportunity to formalise and

		and benefits realisation.	standardise the approach to prioritisation, assessment, and decision-making. To support this, the Trust is establishing the Digital Oversight Group (DOG) and developing a standardised automation intake and governance solution. Together, these arrangements will provide a structured mechanism for the submission, assessment, prioritisation, approval, and oversight of automation opportunities across the organisation. The framework will incorporate defined prioritisation criteria, including factors such as strategic alignment, risk reduction, efficiency gains, capacity release, resource requirements, dependencies, and anticipated organisational benefits. This will provide greater transparency of decision-making and ensure automation capacity is directed towards initiatives delivering the greatest value to the Trust.
			Expected Evidence of Implementation: • Approved Terms of Reference for the Digital Oversight Group • Prioritised pipeline of automation and AI initiatives • Evidence of governance oversight and prioritisation decisions • Review of automation and AI demand, capacity, and resource requirements through established governance processes
		Medium Priority	**Officer:** Wyn Morris, ICT Programme Manager **Target Implementation Date:** 31st December 2026
	Theme: Policies & Procedures	Control Design	

Objective 4: Appropriate processes are in place to fully document the design of automated process and test the final product with the operation of new technology monitored to ensure they operate as expected	**Reasonable**

As noted within previous objectives, there are no standard templates for formally documenting the design of automated processes. Currently, process documentation is maintained in Excel and includes confirmation of testing and identification of target systems. However, it does not provide comprehensive coverage of key elements such as full logical flow of the process, data flows, formal user approval of the design, validation of testing outcomes, and formal approval prior to deployment (see **Key Finding 5**).

While the current level of automation remains relatively limited, which enables direct oversight by the Digital Services team, the absence of structured documentation and formalised processes presents an increasing risk as automation adoption expands. This risk is particularly relevant if development capability is extended beyond the Digital Services Directorate.

Appropriate environment segregation is in place, with separate development, test, and production environments. Automated processes are progressed through these stages appropriately. We note ongoing improvements in change control arrangements, including the introduction of a managed deployment pipeline, which will better track amendments and reduce the risk of unauthorised changes within the production environment.

Processes are in place to monitor the operation of automated solutions. For Blue Prism, this is supported through its command centre, which enables live monitoring of processes. For Power Automate, monitoring is undertaken through a combination of manual review and use of the Power Platform dashboard.

There are established alert mechanisms for process failures, with automated notifications (e.g. email alerts) triggering when issues occur. Consideration is given as part of the development process of where to build in alerts; however, this is not supported by formal guidance and relies on developer judgement and experience (see **Key Finding 5**).

Current monitoring arrangements are largely reactive, with issues identified after failures occur. There is currently no proactive monitoring or warning in place to identify processes that are stalled, running longer than expected, or consuming excessive system resources. While this risk is currently mitigated by the small scale of automation activity, it is likely to increase as usage grows. Incorporating expected run times during testing and embedding timeout controls within automation logic would help mitigate this risk (see **Key Finding 5**).

Key Findings		Risk & Impact	Agreed Management Action
5	**Automated Design, Documentation and Approval** There are no standard templates for documenting the design of automated processes. Existing documentation does not fully capture process logic, data flows, testing validation, user approval, or formal approval prior to deployment.	Automated processes may not operate as intended, resulting in processing errors, data integrity issues, service disruption, or failures that are not promptly detected or effectively managed.	**Agreed Action:** The Trust recognises the importance of ensuring automation solutions are designed, tested, approved, and monitored in a consistent and proportionate manner. Whilst design documentation, testing activities, user validation, DPIA assessment, and governance reviews are already undertaken as part of automation delivery, these arrangements have evolved over time and are not currently supported by a single, standardised framework applied consistently across all automation activity. To support the continued growth of automation and digital innovation, the Trust is developing a standardised automation intake and governance solution, alongside the establishment of the Digital Oversight Group (DOG). These arrangements will provide a structured and consistent approach to the design, assessment, approval, implementation, and monitoring of automation initiatives. The framework will introduce standard templates, documentation requirements, approval processes, and assurance controls, whilst maintaining a proportionate approach based on the complexity, scale, and risk profile of the automation being implemented.
			Expected Evidence of Implementation: • Approved templates and documented procedures • Completed design and testing documentation for new automations • Evidence of formal approvals prior to deployment • Monitoring and alerting standards in place and applied
		Medium Priority	**Officer:** Kara Walsh, ICT Service Desk Manager **Target Implementation Date:** 31st December 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 5: An appropriate process is in place to ensure that changes to the environment in which automated processes operate are assessed for the impact, changes to automated processes are recorded and appropriate continuity planning is in place to enable the organisation to operate in the event of the failure of the technology.	**Reasonable**

The automation of a manual processes enables the release of staff capacity within operational departments, this time can then be reallocated to new tasks. However, it is recognised that automated solutions are inherently sensitive to changes in their operating environment, including updates to underlying systems, applications, interfaces and platforms. Frequent system updates or configuration changes create a risk that automations may fail, leading to a continuous cycle of rework and maintenance. In the case of a failure of automation there may be a need for a temporary return to manual processes.

A Digital Change Board in operation within Digital Services, with representation from the ICT Service Desk Manager, which helps in the identification of system changes that may impact automated processes. However, this process is reliant on individual awareness of automations dependencies and may not consistently identify all potential impacts.

The Trust maintains a record of automated processes, including details of target systems and required permissions, which enables visibility over environmental dependencies. However, this information is not consistently completed and, combined with the absence of detailed process design documentation, this further limits the Trust's ability to fully understand and manage dependencies between automated processes and the wider technical environment (see **Key Finding 7**).

Automation activity within the Trust is currently at an early stage. While Digital Services highlight the need for departments to have continuity arrangements in place to manage potential automation failure, there is no formal requirement for these plans to be documented, reviewed, or approved prior to going live. As a result, there is limited assurance that departments are appropriately prepared to maintain service delivery in the event of automation failure (see **Key Finding 6**).

Key Findings		Risk & Impact	Agreed Management Action
6	**Continuity Planning for Automated Processes** Although departments are advised to maintain continuity arrangements for automated processes, there is no formal requirement to document, validate or approve these arrangements prior to deployment.	Failure of automated processes may disrupt service delivery and require unplanned or unsupported reversion to manual processing, potentially impacting performance and service quality.	**Agreed Action:** The Trust recognises the importance of ensuring appropriate continuity arrangements are considered as part of the development and implementation of automated processes. Responsibility for the development, maintenance, and approval of Business Continuity Plans (BCPs) and Business Impact Assessments (BIAs) remains with the relevant service area, supported through the Trust's Emergency Preparedness, Resilience and Response (EPRR) arrangements. Continuity and resilience considerations are already incorporated within existing governance processes, including through the DPIA process completed for automation initiatives, which requires consideration of business continuity and disaster recovery arrangements. In addition, service owners are expected to consider operational fallback

			arrangements and service continuity requirements as part of the automation design and implementation process. However, the Trust acknowledges that there is an opportunity to strengthen the consistency with which these considerations are formally documented, evidenced, and acknowledged prior to deployment. To support this, the Trust is developing a standardised automation intake and governance solution, alongside the establishment of the Digital Oversight Group (DOG). These arrangements will ensure continuity and operational resilience considerations are explicitly captured as part of the assessment, approval, and implementation process for automation initiatives.
			Expected Evidence of Implementation: • Standardised automation intake and assessment documentation incorporating continuity requirements • Evidence of service owner acknowledgement and approval prior to deployment • Confirmation of departmental ownership of relevant BCP and BIA arrangements
		Medium Priority	**Officer:** Kara Walsh, ICT Service Desk Manager **Target Implementation Date:** 31st December 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
7	**Management of Automation Dependencies and Change Impact** Records of automated processes include target systems and required permissions which enables tracking of environmental dependencies. However, this information is not consistently completed, and there is no formal mechanism to identify, document and assess dependencies between automated processes and their operating environment.	Changes to applications, platforms, or configurations may cause automated processes to fail unexpectedly, leading to processing errors, delays, or service disruption.	**Agreed Action:** The Trust will incorporate dependency management and change impact assessment requirements into the automation governance framework and associated intake process. This will include: • Identification and documentation of system, application, infrastructure, and permission dependencies • Recording of automation owners and key stakeholders • Assessment of potential change impacts during design and implementation activities

			• Consideration of dependencies as part of governance and approval processes • Governance oversight through the Digital Oversight Group These requirements will be embedded within the Trust's automation intake and governance solution to improve visibility of dependencies and support the proactive management of changes affecting automation services.
			Expected Evidence of Implementation: • Completed and maintained dependency records • Documented change impact assessment requirements • Standardised automation documentation and governance processes • Evidence of governance oversight of changes affecting automation
		Medium Priority	**Officer:** Kara Walsh, ICT Service Desk Manager **Target Implementation Date:** 31st December 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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Public Sector Internal Audit Standards

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

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

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Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Digital Business Continuity Management

Final Internal Audit Report 2025/26

Reasonable Assurance

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Review Reference	WAS_2526_15
Fieldwork	November / December 2025
Executive Sign Off	18 June 2026
Audit Committee	September 2026
Executive Lead	Jonny Sammut, Director of Digital
Head of Internal Audit	Osian Lloyd

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Shared Services Partnership
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Executive Summary

Purpose

To review the arrangements in place to enable the continued provision of services in the event of disruption to the digital environment, and to assess the effectiveness of response and recovery processes.

Overview

We have concluded Reasonable assurance for this area.

The Trust has an overarching Business Continuity Policy in place, with continuity plans established for Information and Communication Technology (ICT) and operational departments which outline roles, responsibilities, escalation routes, and actions to be taken in the event of digital disruption. These arrangements are underpinned by Business Impact Assessments to prioritise critical systems. Digital continuity and incident response arrangements have been tested to ensure they are operational, and an appropriate command and communication framework is in place to support effective incident response.

However, the following matters require management attention to strengthen overall resilience and assurance:

- ICT continuity arrangements are maintained across a suite of interrelated documents, but do not currently provide a clear overarching view of how all BIA-identified impacts — particularly non-technical scenarios such as loss of staff and premises — are translated into defined response actions.
- Disaster recovery arrangements are currently dispersed across multiple documents and do not provide a consolidated view of recovery priorities, Recovery Time Objectives (RTOs), Recovery Point Objectives (RPOs), or detailed system restoration procedures, which may reduce clarity during a major incident.
- There is limited evidence of consistent Trust-wide oversight confirming that all departmental business continuity plans are regularly reviewed, remain complementary, are kept up to date, and are exercised in accordance with policy requirements.
- Organisational learning from exercises was not consistently captured and tracked through a central mechanism, limiting assurance that identified actions were systematically progressed and embedded within updated plans.
- While critical systems are identified, the ICT Disruption Plan does not consistently demonstrate a clearly prioritised recovery approach aligned to BIA outputs, or how resources would be dynamically deployed during complex incidents.
- Although dependencies on Digital Health and Care Wales and national systems are documented, there is limited evidence of structured, end-to-end testing, including joint exercises with external partners, to validate these arrangements.

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

Scope & Assurance Summary

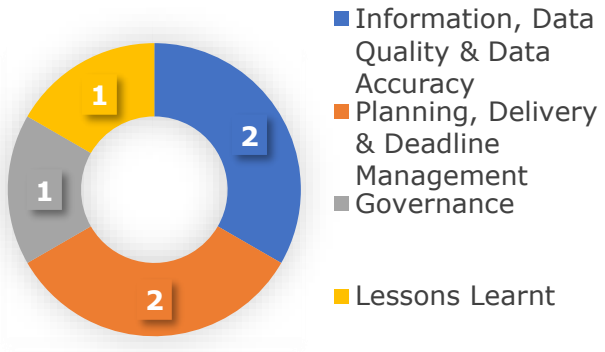
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion)		Related Findings	Assurance
1	Appropriate business continuity plans are in place for Digital Services, along with appropriate backup and disaster recovery arrangements.	1, 2	**Reasonable**
2	Departments understand their responsibilities and have appropriate business continuity plans and supporting processes in place. These enable the Trust's critical operations to cope with the loss of IT functions, consider the potential time lag for restoration of services and include retrospective data capture.	3	**Reasonable**
3	The Trust has processes in place for testing continuity plans and incorporating lessons learned from recent events.	3, 4	**Limited**
4	Plans ensure that resources are available to manage a continuity incident, including out of hours, and are targeted to the most critical systems.	5	**Reasonable**
5	Plans ensure an appropriate command structure and communication mechanism are in place in the event of a continuity event occurring, with dependencies on DHCW and national systems clearly identified.	6	**Reasonable**

Management Actions

1 High Priority

5 Medium Priority

Themes



Themes

Information, Data Quality & Data Accuracy

Findings & Agreed Action Plan

Objective 1: Appropriate business continuity plans are in place for Digital Services, along with appropriate backup and disaster recovery arrangements.	Reasonable

There is a framework in place for enabling Digital Services business continuity, underpinned by a Trust-wide ICT Disruption Plan together with an ICT Disaster Response Plan. The content of these documents aligns with the Trust's overarching Business Continuity Policy, clearly defining escalation procedures, command and control arrangements, and priority actions in response to ICT outages, cyber incidents, and major system failures. These arrangements are further supported by departmental Business Continuity Plans (BCPs).

Business Impact Analyses (BIAs) undertaken across the Trust enable ICT to identify and prioritise critical digital systems, associated dependencies, and Recovery Time Objectives (RTOs). This supports a risk-based approach to digital continuity planning, ensuring focus is placed on systems that are operationally and clinically critical. The ICT Disruption Plan reflects this prioritisation and includes digital-specific considerations, such as fallback arrangements and remote access, to maintain essential services during periods of disruption.

The ICT department has also undertaken a BIA identifying its own critical activities and the impacts associated with the loss of key resources, such as premises, staff, communications and vehicles. While this information is partially incorporated within the ICT Disaster Response Plan, not all identified impacts, such as loss of staff, are fully addressed. The BIA is clear that it should inform the basis of a BCP; however, although elements are covered within the Disaster Response Plan, it does not fully meet this requirement (See **Key Finding 1**).

Backup arrangements are well established and robust, and are clearly defined within a formal procedure. These arrangements ensure systems are protected through automated backup schedules, strong encryption, and continuous monitoring of backup success and failure. The procedure also includes clear processes for onboarding new systems into the backup routine, providing confidence that data is consistently safeguarded. Furthermore, our testing confirmed that the backup and restore functions are appropriate and operating effectively.

The WAST ICT Disaster Response Plan serves as the formal disaster recovery framework for ICT, detailing failover expectations, use of disaster recovery sites, and the roles of structured recovery teams. Detailed technical restoration instructions ae in place for individual services. Management has confirmed that these arrangements are intentionally maintained across a suite of documents to reflect the complexity and interdependency of ICT services and to enable flexibility during incident response.

However, while the plan provides high-level guidance and defines key response actions, key information derived from the BIAs, such as the expected RTOs, Recovery Point Objectives (RPOs), and detailed restoration sequences is not consistently presented in a consolidated format. This may reduce clarity during a major incident, particularly where competing service priorities arise or where rapid decision-making is required (See **Key Finding 2**).

Key Findings		Risk & Impact	Agreed Management Action
1	**Absence of a Complete ICT Business Continuity Plan** While a range of ICT continuity documentation is in place, there is no overarching document or framework that brings together these elements and clearly demonstrates how all BIA-identified impacts — particularly non-technical scenarios such as loss of staff, premises and key resources — are translated into actionable continuity arrangements. Management has confirmed that a deliberate decision has been taken to operate a federated documentation approach, whereby continuity arrangements are managed through a suite of documents, including the ICT Disaster Response Plan, ICT Disruption Plan, BIAs and the wider Trust Business Continuity framework. This approach reflects the integrated nature of ICT services and their reliance on wider organisational infrastructure and incident response arrangements. Internal Audit acknowledges that many elements of continuity planning are in place. However, the absence of a clear overarching structure creates a risk that key impacts identified within BIAs are not consistently or clearly linked to defined response actions, which may reduce usability and clarity during a live incident.	The lack of a complete ICT Business Continuity Plan aligned to the BIA risks inconsistent disruption management and delayed system recovery, impacting critical services.	**Agreed Action** Formalise the federated ICT continuity approach by developing an overarching ICT Continuity Framework that consolidates and references all relevant documentation (e.g. DR Plan, ICT Disruption Plan, BIAs and Trust BC framework). The framework should map key BIA impacts (including staff, premises and resources) to defined response actions, cover both technical and non-technical scenarios, and provide a clear structure for use during incidents. **Expected Evidence of Implementation:** • Approved ICT Continuity Framework (version controlled) • Documented mapping of BIA impacts to response actions • Cross-referenced supporting plans and procedures • Evidence of governance approval • Evidence of communication to relevant staff
		Medium Priority	**Officer:** Assistant Director of Digital - ICT **Target Implementation Date:** December 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

2	**Lack of a Consolidated and Approved Disaster Recovery Plan** Disaster recovery arrangements are currently maintained across multiple documents, including the ICT Disaster Response Plan and detailed technical procedures. While this approach reflects the complexity of ICT systems and supports flexibility in managing incidents, it does not provide a single, consolidated view of recovery priorities, RTOs, RPOs or restoration sequencing. Management has advised that predefined recovery priorities may not always be appropriate given the dynamic nature of incidents and the need to respond in line with operational requirements at the time. Internal Audit recognises the need for flexibility; however, without clearly defined baseline priorities and recovery expectations, there is a risk of inconsistency or competing demands during a major incident, particularly where key decision-makers are unavailable or where multiple critical services are impacted simultaneously.	The absence of a consolidated and approved Disaster Recovery Plan increases the risk of inconsistent and delayed system recovery, leading to prolonged disruption of critical services.	**Agreed Action** Strengthen existing disaster recovery arrangements by introducing a consolidated DR Summary (playbook) to sit above existing technical documentation, defining system priority tiers, baseline RTOs/RPOs aligned to BIAs, and high-level restoration sequencing agreed with key services. **Expected Evidence of Implementation:** • Approved DR Summary / Playbook document • Documented priority tiers for systems/services • Evidence of RTO/RPO alignment with BIA outputs • Records demonstrating engagement and agreement with service areas • Cross-referencing to detailed technical recovery procedures/runbooks Evidence of governance approval
		Medium Priority	**Officer:** Assistant Director of Digital - ICT **Target Implementation Date:** December 2026
	Theme: Planning, Delivery & Deadline Management	Control Operation	

Objective 2: Departments understand their responsibilities and have appropriate business continuity plans and supporting processes in place. These enable the Trust's critical operations to cope with the loss of IT functions, consider the potential time lag for restoration of services and include retrospective data capture.	Reasonable

Our review of a sample of departmental BCPs, including ICT, Computer Aided Dispatch (CAD) system for managing emergency 999 calls, NHS 111 Wales, the Clinical Service Desk, and Emergency Medical Services (EMS) Coordination, confirmed that departments understand their business continuity responsibilities and have documented processes in place to maintain critical operations during the loss of IT systems. Departments have developed practical and workable fallback arrangements, such as manual processes, paper-based forms, and the use of supporting resources including the NHS 111 Fallback Guardian. These arrangements explicitly consider the potential time lag associated with system restoration and are aligned to agreed RTOs and Maximum Tolerable Periods of Disruption (MTPDs), demonstrating that essential Trust activities can continue while digital services are unavailable.

Arrangements for capturing, managing, and restoring information and data generated during system outages are evident across departments. These include the use of manual call logs, paper-based Medical Case Disposition forms, and printed call summaries to ensure operational continuity. Several departments, particularly the Clinical Service Desk, have documented procedures for retrospective data entry and reconciliation once systems are restored, supporting the integrity and completeness of clinical and operational records and ensuring that incidents are appropriately resolved following disruption.

The Trust has a formal Business Continuity Policy which sets expectations that continuity plans remain current, operational, and routinely tested. Departments are required to complete and maintain up-to-date BIAs and BCPs that identify critical activities, dependencies, and risks, and to regularly test these arrangements through scheduled exercises or structured post-incident reviews, with lessons learned documented and applied. Governance mechanisms exist to support this, including version control, annual plan reviews, and a programme of exercising coordinated through the Emergency Preparedness, Resilience and Response (EPRR) team.

However, application of these governance arrangements is not consistent across all departments. There is no evidence of Trust-wide oversight mechanism providing assurance that all departmental BCPs are routinely reviewed, remain complementary and interoperable, are kept up to date, and are tested in line with policy requirements. As a result, some departmental plans have not been reviewed for several years, reducing assurance over their ongoing effectiveness (See **Key Finding 3**).

Key Findings		Risk & Impact	Agreed Management Action
3	**Lack of Trust-Wide Oversight of Departmental Business Continuity Plans** While some departments undertake annual reviews and regular testing of their business continuity plans, there is no Trust-wide oversight mechanism confirming that all departmental plans are routinely reviewed, remain complementary, are kept up to date, and are exercised in accordance with policy requirements.	The absence of Trust-wide oversight creates a risk that continuity plans are not consistently effective, reducing assurance over the Trust's resilience during disruption.	**Agreed Action** Embed and evidence the Trust-wide oversight framework for Business Continuity Plans through Continuity2 and governance arrangements, ensuring consistent application across all departments. **Expected Evidence of Implementation:** • Continuity2 central dashboard/register of departmental BCPs • Evidence of review cycles, version control and testing status • Regular assurance reports to governance forums (e.g. EPRR) • Evidence of follow-up actions where plans are overdue or incomplete • Periodic summary reporting demonstrating overall compliance levels
		Medium Priority	**Officer:** Assistant Director of Digital - ICT **Target Implementation Date:** December 2026
	Theme: Governance	Control Operation	

Objective 3: The Trust has processes in place for testing continuity plans and incorporating lessons learned from recent events.	Limited

The Trust's Business Continuity Policy requires regular testing and review of continuity plans to ensure arrangements remain effective and current. In line with this requirement, a Business Continuity workshop was conducted, which involved structured testing and review activities and bringing together relevant stakeholders to assess preparedness and identify opportunities for improvement.

While the policy requires annual testing of all continuity plans, there is no established mechanism to ensure this occurs across the organisation. We note that some testing has taken place, including a Trust-wide business continuity exercise in November 2024 and participation in the NHS Wales Cyber exercise in September 2025, which enabled ICT to test its arrangements. However, there is no Trust process to ensure and confirm all departments routinely test their plans, and not all the departments whose plans we reviewed took part in the exercises undertaken above (See **Key Finding 3**).

Our review of departmental documentation confirmed continuity plans state that they should be reviewed at least annually, or sooner following an incident or significant change. However, version histories indicate that this has not been applied consistently in practice. Some plans show gaps of multiple years between major revisions, despite the policy requirement for annual review, reducing assurance that plans remain current and effective.

Business continuity and resilience exercises are generally well designed, with scenarios based on credible disruption events and involving a broad range of operational and digital teams. Exercises are planned, delivered, and evaluated against defined objectives, with outputs reported to the Business Continuity Steering Group and Strategic Group. Post-exercise reviews capture facilitator observations, participant feedback, and overall outcomes, demonstrating effective engagement and the ability of exercises to identify both strengths and weaknesses in current arrangements.

However, our review identified weaknesses in the consistent capture and tracking of organisational learning from exercises and incidents. While learning was identified through exercises and documented within exercise reports, this was not consistently recorded within the Trust's designated central tracking mechanism, the Organisational Learning Spreadsheet (OLSS). For example, the OLSS has not been updated to include lessons from the November 2024 business continuity exercise. As a result, there was limited visibility of how actions were monitored through to completion or embedded within updated plans. Until it is consistently and accurately maintained, the OLSS cannot be relied upon to support effective organisational learning, provide assurance, or enable continuous improvement of continuity arrangements.

The exercises reviewed identified a number of weaknesses, including departmental BCPs that were overly generic or lacked detailed recovery procedures, outdated BIAs, inconsistent availability of hard-copy resources for ICT outages, and vulnerabilities in communication resilience. As these issues were not formally recorded within the OLSS, there has been limited evidence of remedial action being taken, undermining the effectiveness of the exercising process and the Trust's ability to strengthen resilience over time (See **Key Finding 4**).

Key Findings		Risk & Impact	Agreed Management Action
4	**Failure to Capture and Act on Organisational Learning from Business Continuity Exercises** At the time of audit, organisational learning from business continuity exercises was not consistently captured and tracked through a single, central mechanism. While exercises identified a range of issues and actions, these were not fully reflected within the Organisational Learning Spreadsheet (OLSS), which is intended to act as the Trust's central record. As a result, there was limited assurance that identified actions were consistently recorded, monitored and progressed to completion, or that improvements were systematically embedded within departmental plans. Consequently, weaknesses identified within departmental BCPs have not been formally tracked or addressed, with some plans remaining overly generic, lacking sufficient detail on recovery procedures, or not identifying essential offline resources required during ICT outages.	The failure to capture and track lessons learned risks recurring weaknesses in continuity arrangements, undermining the Trust's resilience during disruption.	**Agreed Action** Implement a single, consistent mechanism for capturing, tracking and reporting organisational learning from exercises and incidents, ensuring all learning is centrally recorded, assigned ownership and timescales, and embedded within governance reporting. **Expected Evidence of Implementation:** • Updated central learning tracker (e.g. OLSS or equivalent system) containing all relevant exercises • Clearly defined actions, owners and timescales • Evidence of regular progress monitoring and reporting • Demonstration that completed actions have been reflected in updated BCPs and documentation • Governance minutes evidencing oversight and challenge
		High Priority	**Officer:** Patrick Rees, Locality Manager EPRR (Emergency Preparedness, Resilience and Response) Central **Target Implementation Date:** October 2026
	Theme: Lessons Learnt	Control Operation	

Objective 4: Plans ensure that resources are available to manage a continuity incident, including out of hours, and are targeted to the most critical systems.	Reasonable

Our review confirmed that the Trust's continuity documentation, including the Business Continuity Plan 2025, EMS Coordination BCP, ICT Disruption Plan, and National 999 Call Handling BCP, outlines the roles, staffing, and technical resources required to respond to continuity incidents. Plans describe Strategic, Tactical, and Operational command arrangements; minimum staffing levels for Clinical Contact Centres; fallback arrangements for CAD and telephony; and supporting roles such as Duty National Inter-Agency Liaison Officer, (NILO), Tactical Advisors, ICT specialists, and mutual aid arrangements.

Out-of-hours capability is addressed through established 24/7 rotas for Strategic Command, on-call ICT support, and documented escalation processes that enable the timely activation of Business Continuity Cells when required. National 999 call-handling protocols also provide timely escalation pathways during periods of system disruption.

For ICT, resource requirements to enact the continuity arrangements are informed by the BIA, which identifies critical functions and supporting needs. Out of hours ICT support is provided through three on-call rotas covering critical incidents occurring outside normal office hours, with these staff acting as the first point of contact for reporting and managing ICT incidents. In addition, a senior ICT management rota is in place, enabling escalation of significant issues and providing a point of contact for national incidents affecting NHS Wales or UK ambulance services.

ICT resource prioritisation during continuity incidents is guided by BIAs, which identify critical functions and recovery time expectations. Continuity arrangements prioritise maintaining the Trust's most critical services, including 999 and 111 call handling, Computer-Aided Dispatch (CAD) and Mobile Data Terminal, (MDT) availability, core telephony infrastructure, and digital systems essential to patient safety.

However, while critical systems and resource requirements are identified, the ICT Disruption Plan does not consistently demonstrate how recovery activities would be prioritised and coordinated in practice during complex or prolonged incidents. In particular, there is limited clarity on how system recovery sequencing aligns to BIA-defined priorities, and how resources would be dynamically redeployed during prolonged or complex multi-system failures, limiting operational clarity in high impact scenarios (See **Key Finding 5**).

Key Findings		Risk & Impact	Agreed Management Action
5	**Incomplete Prioritisation of ICT System Recovery** The ICT Disruption Plan identifies the Trust's critical systems and supporting resources, but it does not consistently provide a fully prioritised recovery approach aligned with BIA outputs. While recovery expectations are outlined at a high level, there is limited visibility of how system recovery sequencing would be determined in practice, particularly where multiple critical systems are impacted. In addition, while resource requirements are defined, there is limited clarity on how these resources would be dynamically redeployed during prolonged or complex multi-system failures, limiting operational clarity in high impact scenarios.	The lack of a clearly prioritised, BIA-aligned recovery sequence increases the risk of mis-prioritised system recovery, leading to prolonged disruption of critical services during ICT incidents.	**Agreed Action** Enhance the ICT Disruption Plan by introducing a tiered system prioritisation model aligned to BIA outputs, defining system criticality, associated recovery expectations (RTO/RPO), and principles for dynamic reprioritisation during incidents. **Expected Evidence of Implementation:** • Updated and approved ICT Disruption Plan • Documented system categorisation model and definitions • Evidence of alignment with BIA priorities and recovery expectations • Defined prioritisation principles for incident response • Communication of updated prioritisation approach to ICT teams and relevant stakeholders
		Medium Priority	**Officer:** Assistant Director of Digital - ICT **Target Implementation Date:** December 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 5: Plans ensure an appropriate command structure and communication mechanism are in place in the event of a continuity event occurring, with dependencies on DHCW and national systems clearly identified.	Reasonable

The Trust has a defined Strategic, Tactical, and Operational command framework, which is applied across core continuity and incident response documentation. This includes the Business Continuity Plan 2025, ICT Disruption Plan, EMS Coordination Plan, Cyber Incident Response SOP, and National Business Continuity Plan. Roles, responsibilities and escalation routes are clearly articulated, and additional command capacity can be established through Business Continuity Cells and Incident Coordination Centres during significant or prolonged incidents.

A range of communication mechanisms are in place to support continuity incidents, these include Everbridge for mass notification, Microsoft Teams for virtual coordination, Airwave talk groups for secure operational communications, and fallback telephony arrangements for ICT outages. Corporate Communications processes are in place to manage internal and external messaging, including stakeholder engagement and media management. These arrangements have been partially validated through business continuity and cyber incident exercises.

Key dependencies on Digital Health and Care Wales (DHCW) and national systems are documented. Identified dependencies include CAD, NHS 111 systems, Welsh Demographic Service (WDS), the Welsh Clinical Portal, interoperability services, and national telephony capabilities provided by NHS England and BT. Escalation routes to national bodies in the event of cyber or ICT incidents are also defined.

However, although dependencies are well documented, there is limited evidence that these arrangements have been jointly tested with external partners, such as DHCS or national system providers, to confirm the robustness of arrangements or to validate recovery time assumptions. Additionally, while alternative communication tools are in place, there is no recent evidence of an end-to-end test conducted under full ICT outage conditions to confirm the effectiveness of command, coordination and communication arrangements during a major system failure (see **Key Finding 6**).

Key Findings		Risk & Impact	Agreed Management Action
6	**Limited Testing of External Dependencies and ICT Outage Arrangements** Although dependencies on DHCW and national systems are documented, there is limited evidence of joint resilience testing with external partners or through end-to-end ICT outage scenarios. While some exercises and real-world activations have taken place, there is limited evidence of a structured and consistently evidenced approach to testing command, coordination and communication arrangements under full outage conditions. This reduces assurance that these arrangements would operate effectively during a major incident.	Limited resilience testing reduces assurance that command and communication arrangements would function effectively during a major system failure, increasing the risk of service disruption and patient safety impact.	**Agreed Action** Develop and implement a structured resilience testing programme covering ICT continuity, including external dependencies and full outage scenarios , ensuring lessons learned are captured and used to update plans.
			Expected Evidence of Implementation: • Documented annual testing schedule and programme • Records of completed exercises (plans, scenarios, attendance, outputs) • Evidence of external partner involvement where appropriate • Documentation confirming testing of communication and coordination arrangements • Action logs showing learning captured, owned and progressed • Updated BC/ICT plans reflecting tested and validated improvements • Reporting of outcomes to relevant governance forums
		Medium Priority	**Officer:** Assistant Director of Digital - ICT **Target Implementation Date:** December 2026
	Theme: Planning, Delivery & Deadline Management	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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Prioritisation of Findings

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

Public Sector Internal Audit Standards

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

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

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

Agenda Item No.	07

REPORT TITLE

Good Governance Institute Review – Action Plan

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	3 September 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance
Author(s) of report	Trish Mills, Director of Corporate Governance

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 commissioned the Good Governance Institute (GGi) to undertake an external effectiveness review of the board and its supporting governance arrangements. The review has now been completed and was presented to the board on 30 July. The report is attached at annex 1.

2. The review concludes that the Trust is operating from a strong governance foundation and identifies a number of significant strengths across board culture, leadership, governance processes, patient focus and the developing maturity of risk and assurance arrangements.

3. GGi's overall assessment is that this is a good board with the potential to be a really great one.

4. The findings are significant in the context of the Trust's ongoing governance evolution. They provide independent validation of a number of improvement themes already being progressed through revised IMTP reporting, the integrated governance programme and related workstreams, whilst also providing a structured framework through which the board can consider its future governance ambitions and maturity.

5. This paper does not analyse the findings of the review as this was presented to the board (board papers can be accessed here at item 9) on 30 July. ARAC is presented today with an action plan to address the recommendations made by GGi under the six key priority areas.

6. The action plan (that has been reviewed and approved by the executive leadership team) recognises that the GGi review does not identify fundamental governance weaknesses or failures requiring remediation and focuses shifts rather than seismic changes. Some of these shifts have already started and others are more long term changes.

7. Changes to the ways in which committees operate is drawn out by GGi as the shift that is likely to have the single greatest impact on releasing time and improving effectiveness. This paper proposes a framework upon which to base that shift, and a corresponding change to board agendas to accommodate this. Both were discussed in board development on 24 June.

8. The Trust's Standing Orders requires the board to undertake regular and rigorous self-assessment and evaluation of its own operation and performance, and that of its committees, and for committees to provide an annual report to the board. This paper provides a proposal for the 2026/27 quality governance reviews for approval by ARAC that is focused on the action plan and its intended outcomes.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The committee is asked to:

1. Note receipt of the Good Governance Institute (GGi) external effectiveness review of the board and their conclusion that the Trust is operating from a strong governance foundation with the potential to further enhance board effectiveness;

2. Agree the expected maturity levels to be reached by Q3 2027/28 set out under each priority area in the action plan;

3. Agree that the action plan is appropriate to meet address the recommendations and to support the expected maturity levels by Q3 2027/28;

3. Endorse the strategic committee framework and the approach to the six ordinary board meetings per annum for board approval on 24 September, for final approval by the board; and

4. Approve the approach to the quality governance reviews for the board and its committees for 2026/27.

ADDITIONAL PAPER(S)

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

Annex 1 GGi external effectiveness review report

Annex 2 GGi action plan

Annex 3 Committee Strategic Reporting and Assurance Framework

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 risks 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
26 August 2026	ELT meeting

SITUATION

1. The Trust commissioned the Good Governance Institute (GGi) to undertake an external effectiveness review of the board and its supporting governance arrangements. The review has now been completed and is attached at **annex 1**.

BACKGROUND

2. The review formed part of the board's commitment to continuous improvement and good governance. The assessment included observation of board and committee meetings, review of documentation, stakeholder engagement and structured feedback from board members and senior leaders.

3. The review was considered at a board development session on 25 June 2026 and at the board meeting on 30 July 2026, noting that this committee would review and oversee the accompanying action plan as part of the Trust's wider integrated governance programme.

4. This paper focuses on the action plan to address the recommendations across the six key priority areas:

    - Reset committee structures and ways of working
    - Re-anchor strategy as the primary organising principle for the board
    - Improve the quality of insight and reporting
    - Simplify and strengthen assurance routes below the ELT
    - Build on the development of the board skills matrix to identify and actively mitigate priority capability gaps
    - Create protected space for strategic thinking and board development

ASSESSMENT

GGi Action Plan

5. The key findings for each of the themes set out above are described in detail within the report, together with a series of recommendations intended to support the Trust's continued governance maturity and effectiveness. There are 28 recommendations, however four of those (recommendations 24-28) are seen as expected benefits of actions 1-23.

6. A notable feature of the review is the extent to which the recommendations align with work already planned or underway through by the Strategy Planning and Performance team and the integrated governance programme. In particular, there is strong alignment with:

    - board and committee redesign as recommended by the Audit, Risk and Assurance Committee (ARAC) in January 2026
    - enhancement of assurance arrangements
    - strategic reporting redesign
    - improvements to the Board Assurance Framework
    - governance refresh beneath ELT

7. The review therefore provides an externally validated framework through which existing improvement activity can be prioritised and accelerated.

8. The action plan at **annex** 2 is intended as a programme of work which extends to Q3 2027/28 to coincide with that year's quality governance reviews of the board and committees. Each priority area sets out the current maturity level as at Q2 2026/27, and the anticipated maturity level to be reached by Q3 2027/28. For some areas we expect to go up two levels, and in others the increase is slower.

9. The maturity matrix is particularly valuable because it shifts the discussion from the delivery of individual recommendations to a broader consideration of governance maturity. It recognises that improvement is not simply a matter of implementing discrete actions, but of progressively strengthening behaviours, assurance arrangements, strategic focus, organisational decision-making and governance effectiveness over time.

10. The matrix also recognises that different elements of the governance framework will progress at different rates and that not every recommendation needs to be delivered at the same pace. This provides an opportunity for the board to determine where effort should be focused, the pace at which improvement should be pursued and what level of maturity is both desirable and achievable within the Trust's context.

11. The actions set out under each priority area are anticipated to support the attainment of the maturity levels by Q3 2027/28, if not before. The action plan was approved by the executive leadership team on 26 August 2026 and will be monitored by them on a quarterly basis with consideration for any larger elements of the integrated governance programme to be included in the IMTP for 2027-29. ARAC will receive an assurance report quarterly on the integrated governance programme, of which the GGi action plan forms a significant part.

Committee Strategic Reporting and Assurance Framework

12. Recommendations 2, 13 and 14 require a review of the purpose and structure of committees. Whilst it is likely that this framework will be iterated as its applied to the committees, cycles of business are revised, and delivery groups established, it is proposed that the design principles at **annex 3** are a starting point for approval by the board to enable a reset of the committee structures and ways of working.

13. This framework will set the scene for the implementation of the recommendations from ARAC that were approved by the board in January 2026 to restructure remits primarily for ARAC, the Finance and Performance Committee and the Academic Partnerships Committee.

Board Agenda

14. The Board is required to hold six ordinary meetings per year. To move the board to a more strategic footing it is proposed that four meetings a year are explicitly focused on assurance against delivery of strategic objectives, aligned to quarterly reporting, and two meetings retain flexibility to focus on financial assurance, deep dives of selected strategic objectives (deliverables, performance and/or risk), strategic horizon scanning, cultural or regulatory issues, and the annual report and audited accounts.

15. This model is intended to strengthen the board's strategic line of sight, reduce duplication and enable more meaningful scrutiny and challenge at the right level.

16. Flexibility would be retained for extraordinary board meetings or chair's actions, and the private agenda is expected to remain largely unchanged given its reactive nature.

17. Whilst this too will iterate as it's applied, it is a starting point for formal approval by the board.

Quality Governance Reviews of the Board and Committees 2026/27

18. As indicated above, the action plan sets out the proposed ambition for achieving increasing levels of maturity across the governance framework over the next 18 months. It is proposed that this timescale is used as the point at which progress is formally evaluated, allowing sufficient time for actions to be implemented, embedded and their impact assessed. Whilst progress against individual actions will be evident before this point, a longer timeframe is required to determine whether the anticipated benefits and maturity improvements have been realised in practice.

19. Formal evaluation of the overall effectiveness of the programme would then take place through the board and committee quality governance review process (formally known as effectiveness reviews) during Q3/Q4 of 2027/28. This would include seeking feedback from members on progress against the maturity matrix and the extent to which the intended benefits of the improvement actions have been achieved.

20. Members will recall that extensive quality governance reviews of the board and all committees were undertaken during 2024/25. These reviews generated a range of improvement actions and informed the work of the ARAC subgroup during 2025/26 to streamline the governance structure, including reducing the number of committees from seven to six and proposing changes to quorum arrangements. At that time, the quality governance review process adopted a predominantly qualitative approach, seeking members' views on committee terms of reference, membership, aspects that were working well, and areas requiring improvement. In addition, in accordance with Standing Orders (paragraph 10.2.2), annual reports were prepared for each committee demonstrating that delegated responsibilities had been discharged in line with their terms of reference.

21. Standing Orders (paragraph 10.2.1) require the board to undertake regular and rigorous self-assessment and evaluation of its own operation and performance, and that of its committees. It is therefore proposed that the GGi review, together with the recommendations and actions arising from it, provides the foundation for the 2026/27 quality governance reviews.

22. The implementation of the GGi recommendations will inevitably result in changes to committee responsibilities, terms of reference and ways of working, particularly in relation to the Finance and Performance Committee, Quality, Experience and Safety Committee (QUEST) and People and Culture Committee. Much of this work is expected to take place during Q4 2026/27 and Q1 2027/28. It is therefore

proposed that the effectiveness reviews for 2026/27 for these committees focus on the extent to which the agreed changes have been implemented and are beginning to support the intended governance outcomes.

23. For ARAC's 2026/27 quality governance review, the existing National Audit Office effectiveness toolkit will continue to be used. Particular emphasis will be placed on ARAC's role in assuring itself, and the board, that the organisation is structured and governed in a way that supports delivery of its strategic objectives. Many elements of the GGi action plan are integral to the wider integrated governance programme and are therefore central to the assurances expected from ARAC.

24. For the Remuneration and Charitable Funds Committees 2026/27 quality governance reviews, it is proposed that the qualitative approach used in previous years is retained. As these committees are not expected to be significantly impacted by the changes arising from the GGi action plan, effectiveness will continue to be assessed through member feedback regarding what is working well, areas for improvement, and whether terms of reference and membership arrangements remain appropriate, alongside consideration of the annual reports.

25. For Trust Board's, it is proposed that the independent GGi review and associated action plan provide the basis for assessing board performance and effectiveness during 2026/27. Whilst changes to board agendas and assurance arrangements are expected throughout 2026/27, particularly in relation to strategic delivery, strategic outcomes and risk, it is unlikely that these developments will have been embedded sufficiently within that period to demonstrate a measurable shift in effectiveness. For this reason, a fuller evaluation of impact is proposed as part of the 2027/28 effectiveness review cycle, allowing adequate time for the changes to become established and for their benefits to be assessed.

RECOMMENDATION

26. As set out in the front cover.

NEXT STEPS

27. The executive leadership team will be responsible for monitoring delivery and ensuring prioritisation and alignment with the wider integrated governance programme and related improvement activity. ARAC will provide oversight of implementation and seek assurance that actions are translating into measurable and sustainable improvements in governance effectiveness.

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

Welsh Ambulance Services University NHS Trust

Board effectiveness review

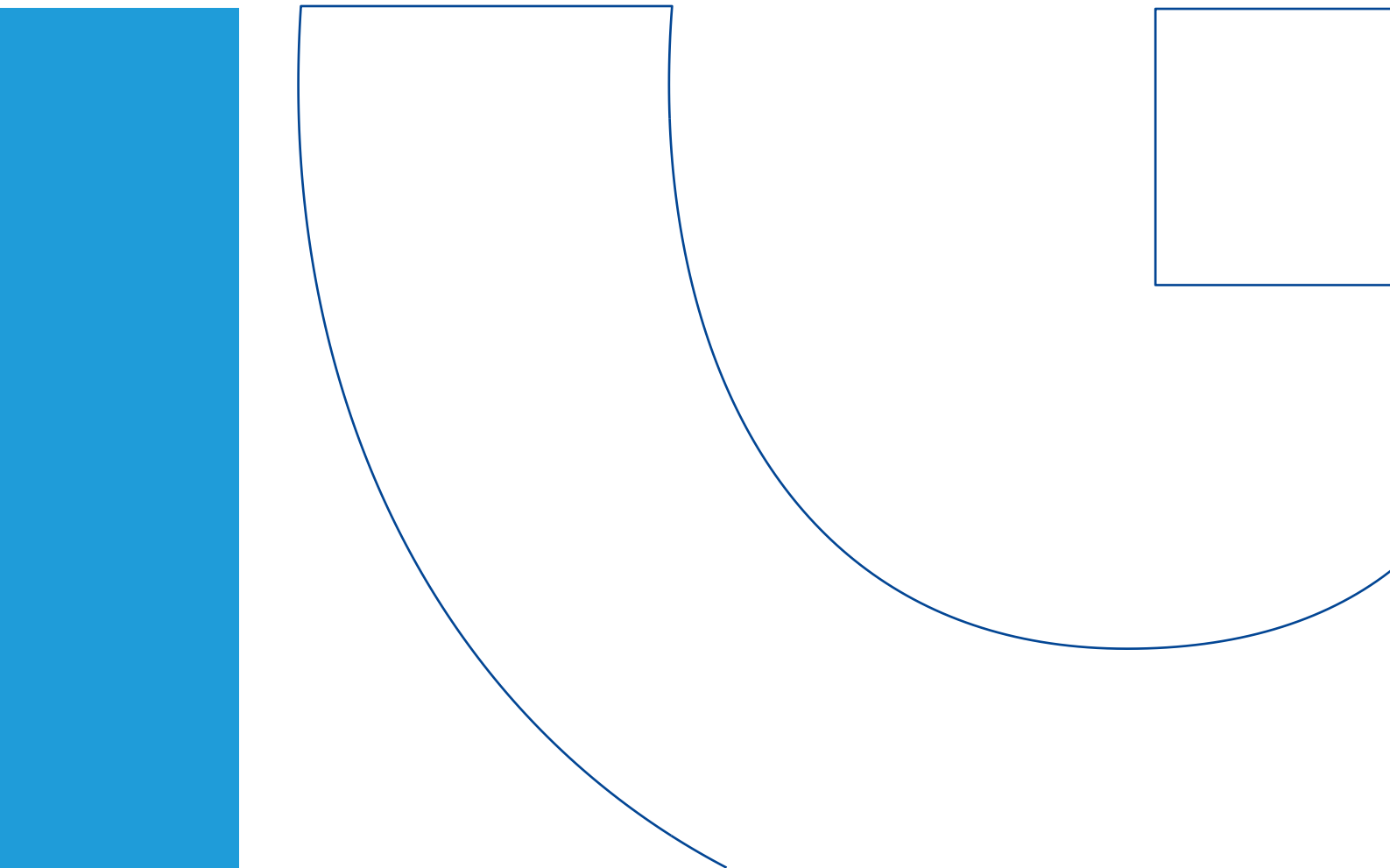
A report from GGi

June 2026

GGi exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat – in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

www.good-governance.org.uk



Welsh Ambulance Services University NHS Trust

Board effectiveness review report

Date:	June 2026
Author/s:	Aidan Rave, Partner Janice Smith, Principal Consultant Sophia Adesoye, Consultant
Reviewed by:	Martin Thomas, Communications Manager

This report has been prepared by GGI Development and Research LLP (T/A GGi) for the Board of Welsh Ambulance Services University NHS Trust. The report highlights the conclusions drawn from the board effectiveness review commissioned by the board and an outline of future suggested actions and improvements to address the identified shortcomings and strengthen the organisation's governance.

The matters raised in this report are limited to those that came to our attention during this assignment and are not necessarily a comprehensive statement of all the opportunities or weaknesses that may exist, nor of all the improvements that may be required. GGI Development and Research LLP has taken every care to ensure that the information provided in this report is as accurate as possible, based on the information provided and documentation reviewed. However, no complete guarantee or warranty can be given with regard to the advice and information contained herein. This work does not provide absolute assurance that material errors, loss or fraud do not exist.

This report is prepared solely for use by Welsh Ambulance Services University NHS Trust. It may be used and referenced internally, including within board papers, annual reporting, and organisational communications. Details may also be shared with specified external stakeholders, including regulators and auditors. Any wider external use or direct quotation attributed to GGi should be agreed in advance. No responsibility to any third party is accepted, as the report has not been prepared for any other purpose.

GGi has carried out client work with around 1,000 organisations over the last decade and a half. We are part-owned by the Good Governance Institute, the EU-based independent governance reference centre focusing on the public and third sectors. We have specific expertise in governance reviews of complex public purpose organisations. Our high-quality and ethical governance consultancy is carried out by our specialist staff team, supported by subject matter expert associates and partners.

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introduction

Context

GGi was commissioned by Welsh Ambulance Services University NHS Trust (WAST) to undertake a developmental review of the effectiveness of its board at a critical point for both the organisation and the wider health and care system in Wales.

WAST operates at the sharpest end of public service delivery. It provides urgent and emergency care, NHS 111 services, and non-emergency patient care services across a national footprint, functioning both as a front-line responder to immediate patient need and as a critical connector within the broader health and care system. Its performance is therefore shaped not only by its own operational capability, but by the resilience, capacity and alignment of the wider system in which it operates.

This creates a uniquely complex governance environment. The board is required to:

- maintain grip on high-volume, high-risk operational delivery
- assure itself on quality, safety and performance in real time
- navigate significant external dependencies and system constraints
- set and sustain a clear strategic direction under conditions of uncertainty.

At the same time, the expectations placed on NHS boards have evolved. There is an increasing emphasis on:

- system leadership, rather than organisational optimisation alone
- population outcomes, rather than service activity
- prevention and transformation, alongside immediate delivery
- financial sustainability in the context of constrained resources.

For WAST, these pressures are particularly acute. The trust sits at a point of constant interface between organisations, with demand patterns, patient flow and performance outcomes heavily influenced by factors beyond its direct control. This increases the importance of the board's ability to operate not only as a steward of the organisation, but as an active leader and influencer within the system; shaping priorities, influencing behaviour and contributing to collective solutions.

Within this context, strong governance is not simply about assurance and compliance. It is about:

- clarity of purpose and direction

- effective prioritisation and decision-making
- the ability to balance short-term pressure with long-term sustainability
- the confidence to lead, challenge and collaborate across organisational boundaries, shape outcomes and ultimately move the dial in relation to constant operational pressure.

This review has therefore been conducted with a deliberate focus on how the board can continue to evolve from a position of sound governance and operational oversight towards a more strategically focused, outward-looking and system-oriented leadership model.

It is important to note that this is not a board in difficulty. Rather, it is a board that has established a solid platform and is now seeking to strengthen its effectiveness in the face of increasing complexity and demand.

Purpose and scope

GGi was appointed by Welsh Ambulance Services University NHS Trust to undertake a thorough and developmental review of its board's effectiveness to ensure it is positioned to meet the complex challenges of today and the future.

Specifically, the review was designed to:

- assess the effectiveness of the board and its supporting committee structure
- evaluate the alignment between governance arrangements and organisational purpose
- examine board culture, behaviours and quality of discussion
- consider the board's ability to provide assurance and maintain strategic oversight
- identify opportunities to strengthen system leadership and future readiness.

Approach and report structure

The findings presented in this report are based on the triangulation of multiple sources of evidence, including:

- semi-structured interviews with board members, executives and key stakeholders
- observation of board and committee meetings
- review of documentation, including board papers and governance frameworks
- benchmarking against characteristics of high-performing boards.

The report is structured to provide an overall assessment followed by detailed analysis across key domains of board effectiveness.

Acknowledgements

The GGi review team would like to thank everyone who made themselves available for interviews and those who provided project support and documentation for review, in particular Trish Mills, Director of Corporate Governance and Alex Payne, Corporate Governance Manager.

Limitations

The review is limited to the documentation that was provided to GGi during the period described, and to the information provided by those we interviewed as part of this process or observed at those meetings we were able to attend. This, together with the other limitations, provides a caveat to the report's findings.

1. Executive summary

"...the board of WAST is a good board, with clear evidence of maturity, professionalism and a shared commitment to improving patient outcomes."

Background

WAST operates in one of the most complex and demanding areas of public service delivery. The board is required to maintain firm operational grip in a high-pressure environment, while also navigating longer-term questions about service model, financial sustainability and system integration.

In this context, the effectiveness of the board is a critical determinant of organisational performance and its ability to improve outcomes for patients.

Headlines

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.

Key strengths

The review identified a number of consistent and reinforcing strengths:

- **Healthy board culture and effective chairing**: the board is well chaired and the tone of board discussion is respectful, open and constructive, with clear evidence of psychological

safety. Challenge is present and generally well received, creating an environment conducive to learning and improvement.

- **Strong use of patient voice**: the use of patient stories is a particular strength, grounding discussion in lived experience and reinforcing the board's focus on quality and impact.
- **Disciplined processes and good quality papers**: board processes are well established, with papers generally clear and focused. The discipline of taking papers as read is embedded and supports efficient use of time.
- **Collegiate and coherent executive team**: executives work effectively across organisational boundaries, presenting a consistent and joined-up leadership narrative.
- **Improving maturity of risk and assurance**: there is clear progress in the board's approach to risk, with improved articulation of risks, controls and assurance mechanisms.

Key development areas

Alongside these strengths, a number of themes emerged consistently:

- **Governance structures are under strain**: committee meetings are lengthy and often overly operational, limiting the board's capacity to focus on strategic matters.
- **Strategy is not consistently used to shape outcomes**: while strategic intent is understood, it is not always actively used to structure discussion, prioritisation and decision-making.
- **Insight is often obscured by volume of data**: reporting contains substantial information but does not always provide clear synthesis or actionable insight.
- **Assurance routes lack clarity below executive level**: complexity in governance below ELT reduces confidence and drives upward escalation of detail.
- **Digital and future readiness are underdeveloped at board level**: this represents a strategic governance gap given the Trust's reliance on technology-enabled service models.
- **Limited space for reflection and development**: the volume and length of meetings constrain opportunities for the board to operate as a developmental forum.

Overall direction of travel

Taken together, these findings point to a clear next phase of development:

- creating space for strategy and forward thinking
- simplifying and strengthening governance architecture
- improving the quality of insight and assurance
- enhancing the board's confidence as a system leader.

These shifts would enable the board to move from a position of strong operational oversight to one of more balanced, strategic and system-focused leadership.

Maturity

We have designed and included a bespoke maturity matrix for the board to consider further developing on the 'good to great' trajectory. This matrix will give the board the opportunity to assess its current level of maturity in relation to a number of relevant themes uncovered within this report – and set out where it would wish to be within a set timeframe.

We strongly suggest this is undertaken as part of a board development process.

Progress can then be tracked, assessed, corrected and subjected to regular review, enabling the board to have clear sight of its progress towards high performance.

The matrix is included within the appendices to this document.

2. Key findings and analysis

Board purpose, strategy and outcomes

The board of WAST demonstrates a clear and shared understanding of the organisation's purpose and the pressures under which it operates. There is a strong – and explicit – sense of commitment to improving patient outcomes and a recognition of the organisation's distinctive role within the wider health system. However, this clarity of purpose is not yet consistently translated into a disciplined, strategy-led approach at board level. In practice, discussions are often shaped by immediate operational pressures rather than structured explicitly through strategic priorities and intended outcomes. This creates a subtle but important gap between knowing the direction of travel and consistently using it to guide decisions, trade-offs and focus. The opportunity for the board is therefore to sharpen the connection between purpose, strategy and delivery, so that strategy becomes a more active and visible organising framework for its work.

In practice:

- discussions are often driven by immediate operational (horizon 1) pressures
- strategic priorities are not always used explicitly to frame decisions or trade-offs
- the connection between performance, quality, finance and workforce is not consistently articulated as a coherent outcomes narrative.

This results in a board that is highly engaged in organisational performance, but less consistently positioned as the strategic 'true north' of the organisation. The Integrated Medium Term Plan 2025 – 2028 reiterates the strategic objectives and while the board discusses this regularly it is only for a short time and does not lead the direction of the agenda.

Recommendations

1. Position strategy explicitly as the primary framework for board agendas and decision-making.
2. Align all board and committee discussions to a set of clear strategic objectives and outcomes.
3. Develop a more integrated narrative linking performance, finance, workforce and patient outcomes.
4. Protect dedicated time for forward-looking strategic discussion.

Board composition, skills and behaviours

The board benefits from a broadly well-balanced composition, combining experience, insight and a clear commitment to the organisation's mission. Members consistently describe a culture that is inclusive, supportive and conducive to participation, particularly for newer appointees. This provides a strong platform for effective governance. At the same time, the evolving context in which WAST operates, particularly the increasing importance of emerging technologies, digital capability, data-driven decision-making and system working, places new demands on board-level skills and confidence. While these areas are recognised, they are not yet fully embedded as areas of collective strength.

As a result, the board's ability to provide consistent, confident challenge on future-facing issues is somewhat constrained. The opportunity is therefore not to rebalance the board wholesale, but to be more explicit and deliberate about capability development and how key gaps are mitigated over time. This should be viewed as a huge opportunity. Given the trust's dependency on digital infrastructure and transformation, this is an area of strategic governance development rather than technical.

We understand that the external appointment process constrains the board's ability to shape its own composition. This makes it particularly important to be explicit about priority capability gaps, including digital, and how they are mitigated through development or external support. There is scope here for more deliberate board development, particularly to build confidence and literacy in digital, system working and future service models enabling stronger strategic challenge and foresight.

Recommendations

5. Agree a clear statement of priority board capabilities.
6. Implement a targeted development programme focusing on digital, data and system working.
7. Consider use of external advisers or panels to strengthen oversight.
8. Increase exposure to innovation and emerging service models.

Relationships, culture and system working

Relationships within the board and between executive and non-executive members are a clear strength of WAST's governance. The culture is characterised by trust, openness and a high degree of psychological safety, with individuals feeling able to contribute, question and reflect without defensiveness. This provides an important foundation for effective collective leadership.

However, there are occasions where the same cultural strengths, particularly collegiality and mutual respect, can temper the effectiveness of challenge, especially on complex or system-wide issues. In addition, while there is clear recognition of the organisation's dependence on the wider system, this can at times translate into a degree of acceptance of external constraints rather than a more assertive stance on shaping outcomes. The next stage of development is therefore about sustaining this positive culture while increasing clarity, confidence and intent in both internal challenge and external system leadership. The opportunity is for the board to be more explicit about what it will own, what it will influence and where it will actively shift the system rather than accommodate it.

So, overall, the board's internal culture is a clear strength, characterised by trust, openness and constructive engagement.

However, there is some evidence that:

- challenge can occasionally lack focus
- system constraints are sometimes accepted rather than actively shaped.

This reflects a board that is collaborative and mature, but which could operate with greater clarity of intent in its system role.

Recommendations

9. Strengthen the consistency and effectiveness of challenge. Sharper challenge in this context includes:
    - linking questions explicitly to strategic objectives and outcomes
    - testing underlying assumptions and use of evidence
    - maintaining focus on areas of greatest risk or impact
    - ensuring clarity on what decisions or actions are required.
10. Clarify the board's ambition in relation to system leadership.
11. Be explicit about areas of influence and control.
12. Use external perspectives to test assumptions and stretch thinking.

Governance structures and assurance

The formal governance framework within WAST is well established and broadly aligned with expected standards for an organisation of its size and complexity. Committees are well supported, roles are understood, and there is a clear commitment to maintaining robust oversight. However, in practice, the system is currently carrying a significant operational load. Committees – particularly the quality, patient experience and safety committees – cover too much ground. Committee agendas are extensive, papers are detailed, and discussions are often drawn into operational territory. Long committee meetings reduce decision quality, limit strategic focus and crowd out reflection. Time spent does not consistently translate into better assurance or clearer direction. This is compounded by a lack of consistent clarity and confidence in assurance routes below executive level, which drives additional reporting and escalation.

The cumulative effect is a governance structure that, while fundamentally sound in design, is overly complex and inefficient in operation, limiting strategic focus and placing considerable demand on board and executive capacity. The opportunity is to simplify, clarify and rebalance the system so that it provides assurance more effectively while freeing up space for strategic leadership.

Key issues include:

- excessive length and operational focus of committee meetings
- high volume of reporting
- lack of confidence in assurance routes below ELT.

This drives escalation of detail and reduces the board's ability to focus on its core role of oversight and direction.

Consideration of previous committee streamlining proposals

As part of this review, we have considered the proposal previously developed through the audit, risk and assurance committee (ARAC), and subsequently recommended to the board, regarding the streamlining of committee structures and associated adjustments to remit.

The evidence gathered through this review strongly reinforces the underlying rationale for simplification. In particular, the current extent of committee agendas, the operational depth of discussion, and the volume of reporting all suggest that the governance system is carrying unnecessary complexity and is not always optimised for strategic oversight or effective assurance.

However, the effectiveness of any restructuring will depend less on the specific configuration adopted, and more on the clarity of purpose and discipline applied within it. Streamlining should therefore be guided by a small number of design principles:

- **Clarity of purpose:** each committee should have a clearly defined role aligned to strategic priorities and key risks

- **Focus on value:** agendas should be structured around decision-making, assurance and learning, rather than comprehensive reporting
- **Avoidance of duplication:** responsibilities should be clearly delineated to reduce repetition between committees and the board
- **Alignment to assurance flows:** committee structures should support a clear and coherent pathway from operational risk to board-level assurance.

The earlier ARAC proposal provides a credible starting point for this work. The opportunity now is to ensure that any structural adjustments are explicitly aligned to the wider objective of creating a more streamlined, strategically focused and effective governance system.

Further redesign of committee structures should be explicitly driven by strategic priorities and the board assurance framework, ensuring that governance architecture reinforces rather than dilutes the organisation's strategic intent.

Recommendations

13. Undertake a fundamental review of committee purpose and structure.
14. Redesign agendas to focus on key strategic risks and decisions.
15. Simplify assurance routes and clarify escalation pathways.
16. Strengthen governance below ELT to improve confidence and reduce reporting burden.

Performance, quality and patient experience

The board demonstrates a strong and visible commitment to patient care, quality and safety. This is reflected in the consistent use of patient stories, which are handled with seriousness and empathy and serve to ground discussion in lived experience.

Performance and quality are a regular and substantive part of board and committee agendas, and there is clear intent to understand and respond to areas of concern. However, the way in which information is currently presented can limit the board's ability to extract maximum value from these discussions.

Reporting is often characterised by high volumes of data, with relatively less emphasis on synthesis, insight and forward-looking analysis. As a result, it can be more difficult to identify underlying trends, root causes and the most impactful areas for intervention. The opportunity is therefore to shift from a model of comprehensive reporting to one of focused insight, enabling the board to engage more strategically with performance and quality issues.

The key rate limiting factors are principally:

- high volumes of data
- limited synthesis
- insufficient focus on forward risk and preventative action.

This makes it harder for the board to consistently focus on where it can have the greatest impact.

Recommendations

17. Refocus reporting on insight, trends and implications.
18. Strengthen analysis of causation and forward risk.
19. Integrate reporting across quality, performance and workforce.
20. Increase emphasis on learning and improvement actions.

Innovation and future-readiness

The board shows a clear awareness of certain aspects of organisational risk, most notably in relation to cyber security, where oversight and attention are relatively well developed. However, broader considerations of digital maturity, data capability and future service models are less consistently embedded in board-level thinking and governance. Responsibility for digital and innovation is dispersed across structures, which can dilute ownership and make it more difficult to develop a coherent view of risk, opportunity and investment.

Given the scale of change facing urgent and emergency care, and the increasing reliance on technology-enabled solutions, this represents a strategic area of relative underdevelopment. The opportunity is not simply to strengthen technical oversight, but to ensure that future readiness – particularly digital and data capability – is treated as a core strategic concern at board level.

Recommendations

21. Establish clearer governance of digital and innovation.
22. Improve board visibility of digital strategy and investment.
23. Build confidence and literacy in digital issues.
24. Embed structured horizon-scanning in Board activity.

Board dynamics, decision making and reflection

Board meetings are well conducted, with a calm, respectful and constructive tone that supports participation and orderly discussion. Newer members describe the environment as safe and inclusive, and which supports participation and confidence. Decision-making processes are generally clear and transparent, and there is evidence of thoughtful consideration of issues as they arise. However, the overall effectiveness of board discussion is influenced by the volume and density of material being considered. Routinely long agendas, detailed papers and extended committee reporting can make it more difficult to distinguish between general oversight and those issues requiring focused attention and decision. The risk should be obvious; if everything is important, then nothing is important.

In addition, while there is genuine capacity for reflection, the current structure of meetings allows limited space for deeper collective consideration or development. The result is a board that is functioning well, but which could operate with greater clarity and impact through reduced volume, sharper prioritisation and more deliberate use of reflective time.

Critically:

- volume of material can dilute focus
- time for reflection and development is limited
- strategic prioritisation is not always explicit.

This includes creating more deliberate space for:

- structured board development sessions
- forward-looking discussions (horizons 2 and 3)
- reflection on areas of influence and control, plus the use of external perspectives to test assumptions
- development in key strategic areas such as digital, data and system working.

The intention is not simply to create more time, but to use that time more explicitly for collective reflection, learning and strategic development.

Recommendations

25. Reduce volume and increase clarity of board material.
26. Make prioritisation and trade-offs more explicit.
27. Create structured opportunities for board reflection.
28. Protect time for development and collective learning.

3. Conclusions

The board of Welsh Ambulance Services University NHS Trust is operating from a position of clear underlying strength. It is well led, well supported and characterised by a positive, respectful and constructive culture. There is a strong and visible commitment to patient care, and a genuine willingness among board members to reflect, learn and improve.

These are not trivial assets. In an environment as pressured and complex as that faced by WAST, the presence of a stable, mature and values-driven board provides an essential foundation for effective governance and organisational resilience.

However, the context in which the board is operating is evolving rapidly. Demand continues to rise, system constraints remain significant, and expectations of NHS organisations, particularly in relation to integration, transformation and long-term sustainability, are increasing. In this environment, the requirements of board leadership are also changing.

The central finding of this review is that the board's next phase of development is not about addressing fundamental weaknesses, but about making a set of focused, deliberate shifts that will enable it to operate with greater clarity, confidence and impact. In keeping with the current NHS vernacular, we've deliberately chosen to describe these as shifts, but they should not be seen merely as signals, rather as critical components of a clear route map towards a high-performing board.

These shifts can be summarised as follows:

- **From operational dominance to strategic balance**
  While maintaining necessary grip, the board will need to create and protect more space for strategic thinking, prioritisation and forward planning.
- **From volume of information to clear insight**
  Strengthening the translation of data into meaningful analysis, trends and actionable intelligence will materially improve the quality of discussion and decision-making.
- **From complex structures to streamlined assurance**
  Simplifying governance arrangements and strengthening confidence in assurance routes will reduce unnecessary burden and sharpen focus at board level.
- **From organisational focus to system leadership**
  The board has an opportunity to define more explicitly how it will act as a leader within the wider system – shaping, influencing and, where necessary, challenging the environment in which it operates.

- **From capability gaps to future readiness**
  Addressing areas such as digital, data and innovation will be essential to ensuring the board is equipped to lead the organisation through the next phase of service transformation.

Importantly, these are all within the board's gift to address. They do not require wholesale redesign or structural upheaval, but rather a combination of:

1. Clear intent
2. Collective discipline
3. Targeted adjustment to ways of working

If these changes are made, the impact will be significant. The board will be better positioned to:

- focus its time and attention on what matters most
- make clearer and more confident decisions
- strengthen its contribution to system-wide outcomes
- support the organisation in navigating an increasingly complex future.

In summary, WAST is governed by a board that is already good and has many of the characteristics required for high performance. With a relatively small number of well-judged changes, it has a clear opportunity to become a consistently high-performing, strategically confident and system-leading board, capable of meeting the challenges ahead and improving outcomes for the patients and communities it serves.

Priority actions for the next 12-18 months

These actions are not all deliverable in the immediate term. Improvements in areas such as insight, reporting quality and governance redesign will require sequencing and sustained focus over time, with some changes implemented incrementally.

1. Reset committee structures and ways of working

Undertake a focused redesign of committee purpose, agendas and reporting to:

- reduce meeting length and operational detail
- sharpen focus on strategic risks, assurance and decision-making
- improve the flow of information between committees and the board.

This is likely to have the single greatest impact on releasing time and improving effectiveness.

2. Re-anchor strategy as the primary organising principle for the board

Ensure that strategy is consistently used to frame:

- board agendas and forward planning
- decision-making and prioritisation
- the articulation of outcomes and success.

This will support a clearer line of sight between purpose, delivery and impact.

3. Improve the quality of insight and reporting

Shift the emphasis of reporting from volume of data to clarity of insight by:

- strengthening analysis of trends, causation and forward risk
- reducing duplication and unnecessary detail
- presenting a more integrated narrative across performance, quality, workforce and finance.

This will enable more focused discussion and better-informed decisions.

4. Simplify and strengthen assurance routes below ELT

Clarify governance and assurance arrangements beneath executive level to:

- increase confidence in the robustness of assurance
- reduce unnecessary escalation of detail

- enable committees and the board to focus on key issues

This will help address current system 'drag' within governance structures.

5. Build on the development of the board skills matrix to identify and actively mitigate priority capability gaps

This should include not only identifying gaps (e.g. digital, clinical, infrastructure, decarbonisation), but agreeing how these will be addressed through a combination of:

- targeted development for existing members
- use of external expertise or advisory input
- structured exposure to relevant areas (e.g. site visits, briefings).

The focus should move from identification of gaps to active mitigation and ongoing capability development.

6. Create protected space for strategic thinking and board development

Deliberately rebalance board time to include:

- forward-looking strategic discussion
- system-level considerations and partnerships
- collective reflection and development.

This will support the transition from a predominantly operational focus to a more balanced, high-performing board.

How these priorities should be approached

These actions are interdependent and should be approached as a coherent programme of improvement, rather than a set of isolated initiatives. Progress is likely to be most effective where:

- there is clear sponsorship from the chair and chief executive
- the board secretary is empowered to lead governance redesign
- changes are sequenced and tested, rather than implemented all at once.

Taken together, these priorities provide a practical route for the board to build on its existing strengths and move confidently to the next phase of its development.

Appendices

Methodology

This review was undertaken using a well-established technique grounded in the triangulation of evidence. GGi's review process used a variety of materials, templates and benchmarking tools to guide various review activities, which have included:

- semi-structured interviews with key board members, executives and stakeholders
- a review of relevant governance documentation
- six meeting observations
- an effectiveness survey of board members.

Key Lines of Enquiry (KLoE)

Area	
Board purpose, strategy & outcomes	1. How clearly does the board articulate a shared purpose and long-term ambition for the trust? 2. How well does the board balance urgent operational pressures with strategic, future-focused oversight? 3. In what ways does the board ensure strategy is shaped by evidence, patient need, community insight, and system-wide collaboration? 4. How effectively does the board monitor outcomes and adjust course when needed?
Board composition, skills & behaviours	5. Does the board have the right blend of skills, experience, and diversity for the challenges facing WAST and the wider Welsh NHS? 6. How effectively are board members supported through induction, ongoing development, and reflection? 7. Are board behaviours conducive to positive challenge, curiosity, and psychological safety? 8. How well does the board assure itself about succession planning and talent development at senior levels?
Relationships, culture & system working	9. How strong and trust-based are relationships between board members, the executive team, and wider leadership? 10. Does the board model and promote a culture of openness, learning, and improvement?

	11. How effectively does the trust work with partners (e.g., other NHS Wales organisations, local authorities, emergency services) to deliver system-wide impact? 12. How well does the board hear and act on staff voice?
Governance structures & assurance	13. Are governance structures (committees, reporting lines, controls) proportionate, effective, and clearly understood? 14. How well does the board gain meaningful assurance on quality, patient safety, workforce, finance, digital, and transformation? 15. Does the board receive information that is timely, concise, insightful, and forward-looking? 16. How effectively are risks identified, escalated, owned, and mitigated?
Performance, quality & patient experience	17. How well does the board understand operational pressure points and system constraints? 18. Does the board maintain a clear line of sight from performance to patient experience and staff wellbeing? 19. How well does the board encourage a learning culture around incident reporting, innovation, and service improvement? 20. How effectively does the board ensure equality, diversity, and inclusion are embedded in care and decision-making?
Digital, innovation & future readiness	21. How effectively does the board oversee digital transformation and data strategy? 22. Is there a clear vision for the future ambulance service, including integrated urgent care, alternative clinical pathways, and technology-enabled models? 23. How strong is the board's oversight of cyber security, data quality, and digital literacy?
Board dynamics, decision-making & reflection	24. How well does the board use its time – balance between assurance, strategy, and learning? 25. Are decisions timely, transparent, and based on high-quality insight? 26. Does the board regularly evaluate its own effectiveness? 27. How well does the board learn from internal and external feedback?

Interviews

Name	Role
Emma Wood	Chief Executive
Lee Brooks	Executive director of operations
Liam Williams	Executive director of quality and nursing
Andy Swinburn	Executive director of paramedicine
Rachel Marsh	Executive director of strategy, planning and performance
Chris Turley	Executive director of finance and corporate resources
Angela Lewis	Director of culture change
Carl Kneeshaw	Director of people
Estelle Hitchon	Director of partnerships and engagement
Trish Mills	Director of Corporate Governance/Board Secretary
Leanne Smith	Interim director of digital

Name	Role
Colin Dennis	Chair
Ceri Jackson	Vice Chair
Rhiannon Beaumont-Wood	Non-executive director
Jayne Beeslee	Non-executive director
Peter Curran	Non-executive director
Bethan Evans	Non-executive director
Hayley Hutchings	Non-executive director
Hannah Rowan	Non-executive director
Meshack Ezeadim	Aspiring board member
Fflur Jones	Performance auditor, Audit Wales
Osian Lloyd	Head of internal audit
Ross Whitehead	JCC
Hugh Parry	Trade union partner
Damon Turner	Trade union partner

Meeting observations

Meeting	Date
WAST Board meeting	26 March
Quality, Patient Safety and Experience Committee (I and II)	3 February
People and Culture Committee (I and II)	10 February
Finance and Performance Committee (I)	17 March
Audit, Risk and Assurance Committee	2 March
Executive leadership meeting (formal)	4 March

Documents reviewed

- Board and committee papers
- Board and committee cycle of business
- Board development plans
- Board and committee effectiveness annual reports
- Board and committee attendance records
- Board skills assessments
- Previous board workshop reports
- Report writing guides and templates
- Scheme of reservation and delegation
- Board assurance framework and risk management documentation
- Board and committee induction programme
- Board visibility and engagement plans

Full list of recommendations

Area	Recommendations
Board purpose, strategy and outcomes	1. Position strategy explicitly as the primary framework for board agendas and decision-making. 2. Align all board and committee discussions to a set of clear strategic objectives and outcomes. 3. Develop a more integrated narrative linking performance, finance, workforce and patient outcomes. 4. Protect dedicated time for forward-looking strategic discussion.
Board composition, skills and behaviours	5. Agree a clear statement of priority board capabilities. 6. Implement a targeted development programme focusing on digital, data and system working. 7. Consider use of external advisers or panels to strengthen oversight. 8. Increase exposure to innovation and emerging service models.
Relationships, culture and system working	9. Strengthen the consistency and effectiveness of challenge. Sharper challenge in this context includes: a. linking questions explicitly to strategic objectives and outcomes b. testing underlying assumptions and use of evidence c. maintaining focus on areas of greatest risk or impact d. ensuring clarity on what decisions or actions are required. 10. Clarify the board's ambition in relation to system leadership. 11. Be explicit about areas of influence and control. 12. Use external perspectives to test assumptions and stretch thinking.
Governance structures and assurance	13. Undertake a fundamental review of committee purpose and structure. 14. Redesign agendas to focus on key strategic risks and decisions. 15. Simplify assurance routes and clarify escalation pathways. 16. Strengthen governance below ELT to improve confidence and reduce reporting burden.
Performance, quality and patient experience	17. Refocus reporting on insight, trends and implications. 18. Strengthen analysis of causation and forward risk. 19. Integrate reporting across quality, performance and workforce. 20. Increase emphasis on learning and improvement actions.
Innovation and future-readiness	21. Establish clearer governance of digital and innovation. 22. Improve board visibility of digital strategy and investment. 23. Build confidence and literacy in digital issues. 24. Embed structured horizon-scanning in Board activity.

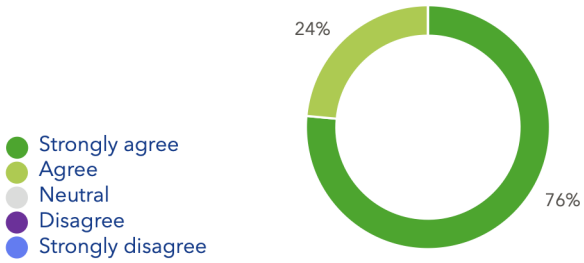
Board dyanmics, decision making and reflection	25. Reduce volume and increase clarity of board material. 26. Make prioritisation and trade-offs more explicit. 27. Create structured opportunities for board reflection. 28. Protect time for development and collective learning.

Board effectiveness survey responses

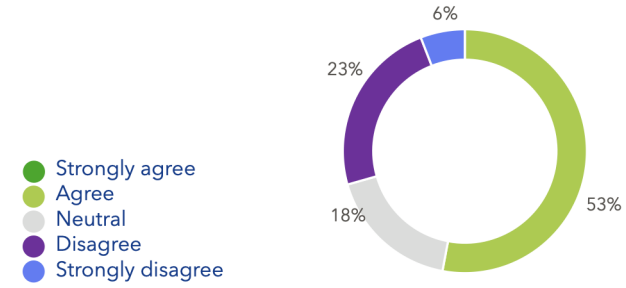
The board effectiveness survey conducted as part fo this review was completed by 17 individuals. Seven executive directors of the board, six non-executive directors, and fouth "other" members.

Survey responses

I understand the organisation's purpose and strategic priorities



The Board spends sufficient time on long-term strategy rather than short-term operational issues



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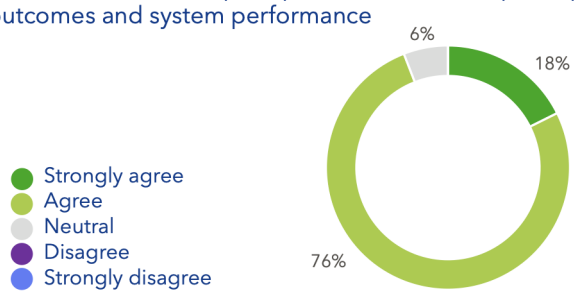
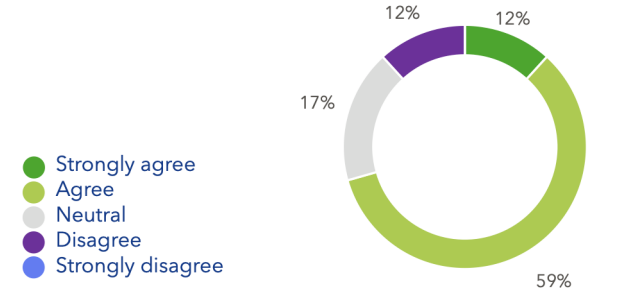
Survey responses

Board discussions help shape decisions that improve patient outcomes and system performance



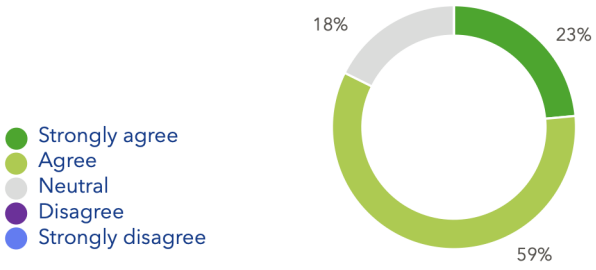
The Board has a shared view of what success looks like over the next 3–5 years



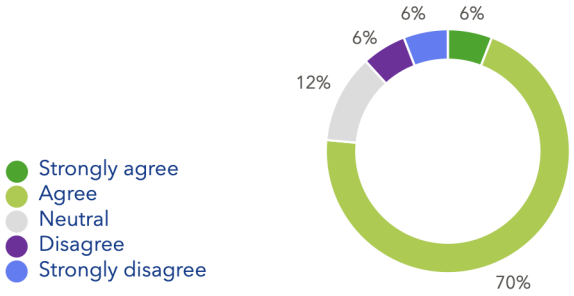
9

Survey responses

The Board has a clear understanding of the key risks to achieving strategic objectives

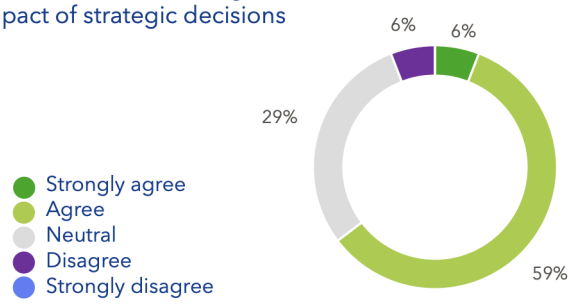


The Board receives appropriate data and insight to assess whether strategic objectives are being delivered

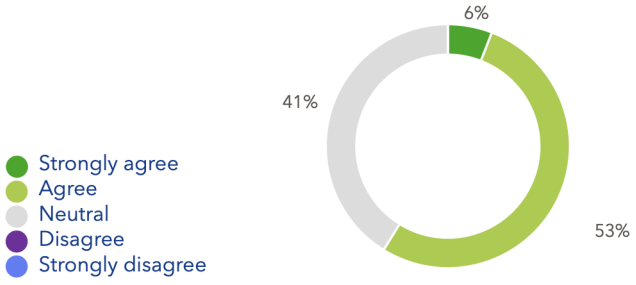


Survey responses

The Board uses meaningful outcome measures to understand the impact of strategic decisions

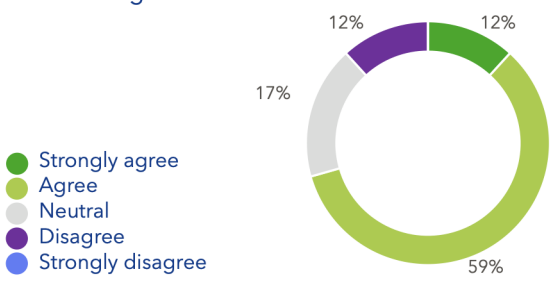


Outcome and performance data are used by the Board to inform future strategic decisions and adjustments

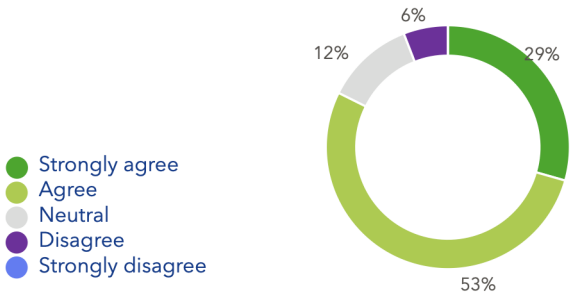


Survey responses

The Board has an appropriate mix of skills and experience for its current challenges

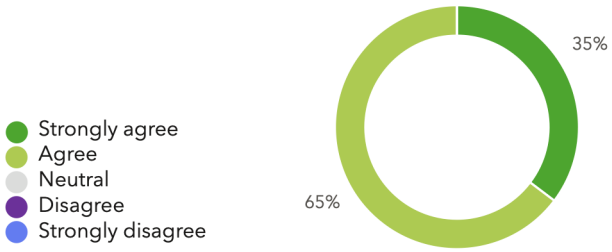


I have the support, induction, and development I need to be effective in my role

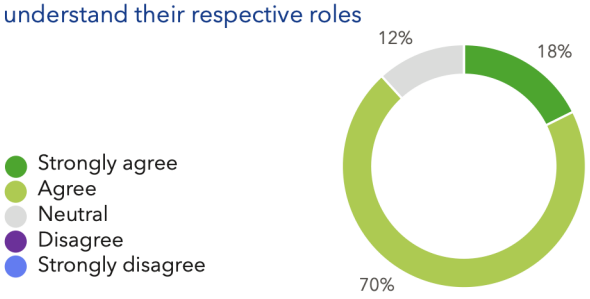


Survey responses

Board members treat each other with respect and demonstrate constructive challenge

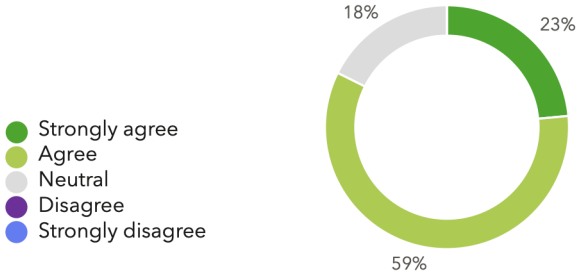


Non-executives and Executives work together effectively and understand their respective roles

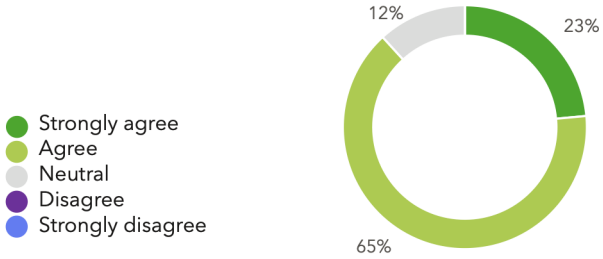


Survey responses

The tone of meetings encourages open, honest, and psychologically safe contributions

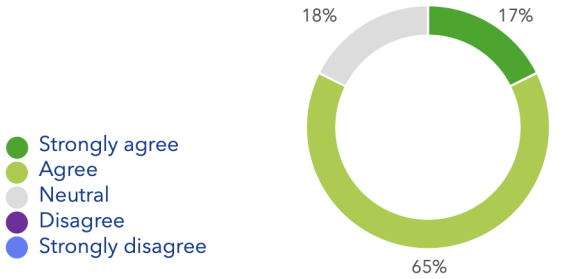


The Chair ensures balanced discussion, includes all voices, and keeps the Board focused on its role

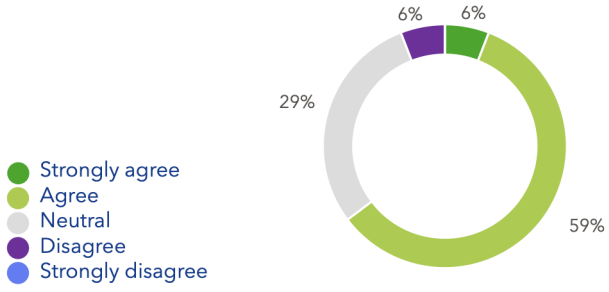


Survey responses

Board papers are clear, timely, and provide the right information for decision-making

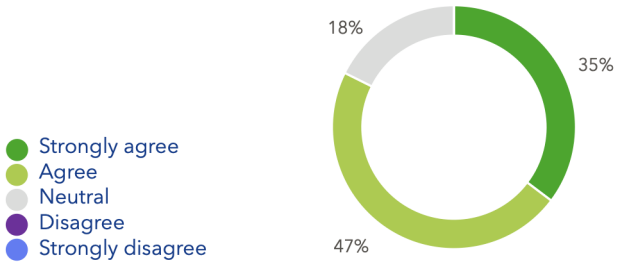


Performance and quality dashboards (MIQPR) give me confidence that I understand the organisation's true position

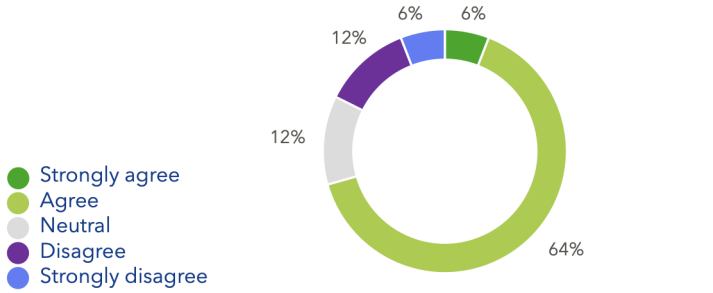


Survey responses

Risk registers and risk dashboards give me confidence that I understand and the organisation's true position

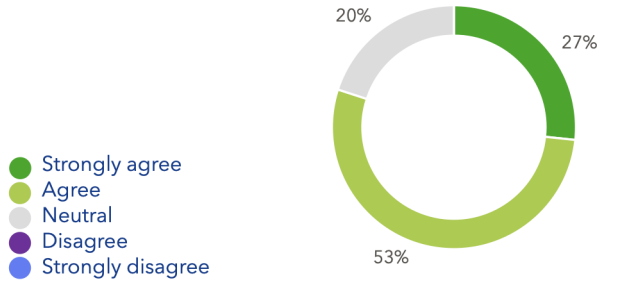


I am satisfied with the quality of reporting on patient safety, quality, and operational performance

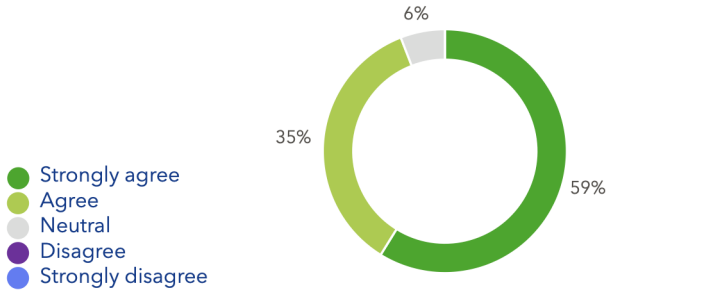


Survey responses

The Board has a strong grasp of the organisation's key risks and mitigations

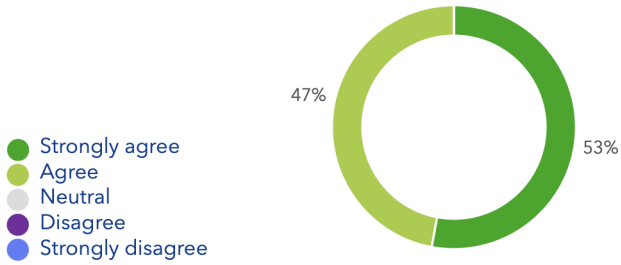


Committees provide effective assurance and escalate issues appropriately

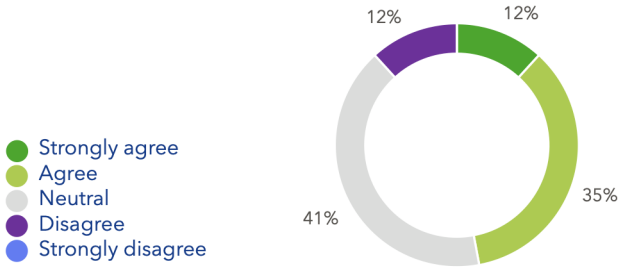


Survey responses

Committee escalations to board are clear, consistent, and appropriate

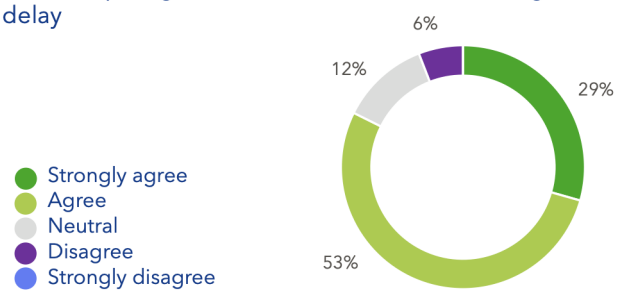


Escalated issue focus on the board's strategic oversight role and do not pull the board into operational management

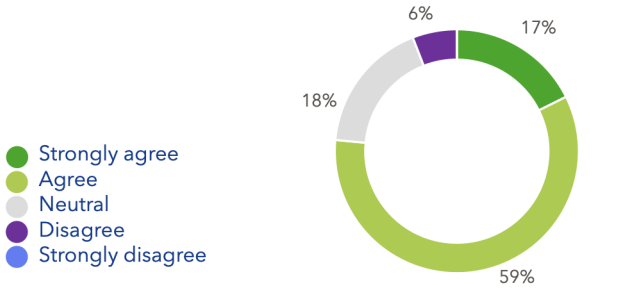


Survey responses

Issues requiring escalation are escalated at the right time and without delay

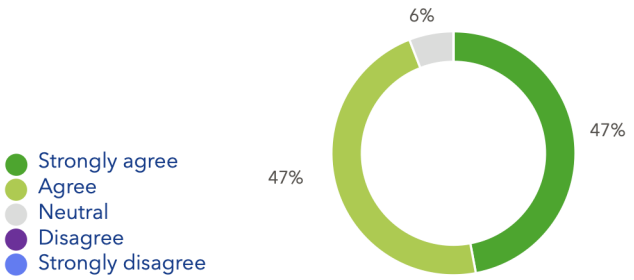


The current governance cycle (committee to board) supports tim ely and effective decision-making



Survey responses

Escalations from committees provide sufficient context, analysis, and assurance for the Board to understand the significance of the issue



Survey qualitative responses

Q1: What one behavioural change would most improve board effectiveness?

- Undertaking deep dives in directorates to get a detailed understanding of issues and having sufficient time in respective committees to discuss
- Wider understanding of the financial position
- Recognition of our challenges, which require calmness of decision making and a keen focus on delivering the changes required
- Opportunities for relationships to forge stronger ties as a unitary board between the various representative groups
- There is a tendency to curtail conversation, more as a function of time rather than of importance. I would like to see this happen less often.
- Reduced length of committee meetings. There are also sometimes many attendees to meetings not necessarily contributors. This must be absorbing much needed capacity. There is arguably opportunity to be more focused.
- Spending more time surfacing debate and thinking about how we can all use our forum to improve system work and contributions
- Truly recognising the competing challenges that occur for partners across the NHS in considering how we play our part in the system
- A shift in NEDs focus from too much of the operational detail and instead focusing more on strategic direction.

- Don't close down discussion too quickly. It sometimes feel we are rushing to get through the agenda.
- More time on development as a team
- Active participation from all board members
- Not rushing through agendas and ensuring sufficient time to discuss the important issues.
- As a board to spend more time together so as to get to know ourselves better including understanding the full skills and experience we have collectively. I don't feel we know this currently. This would help shape contributions at board.
- More constructive challenge from NEDs and more support from executives

Q2: What strategic areas should the board focus on more?

- Clinical outcomes
- Ensuring the Clinical Model Transformation keeps the current pace of delivery as this will be the prime method of addressing our day to day challenges
- Area for focus would be to ensure Board and Committee agenda and reporting takes account overall of strategic direction rather than individual deliverables linked to the annual plans.
- A full appreciation of WAST's position in the system, external reputation, the dynamics at play and need for greater influencing and acceptance of the requirement for improvement within the organisation would lead to a more acute focus on the importance of strategy, strategic decision-making and more constructive challenge.
- The Board should look to review data with a forward look and not just a look back. The board understanding how improvement can be made and then measured would be useful and is critical for offering assurance that it knows the issues, how to resolve them and when such improvements will be made.
- Population outcomes and how WAST can increase the role it plays in reducing inequalities in outcomes
- The one SO that is weakest is probably this: SO6b: Commercial/Foundation Economy, Value-Based Healthcare & Environmental Sustainability
- Defining more clearly what delivery of a strategic objective looks like in any one year. i.e. what does good look like. We seem to have moved away from that. Whilst we now have a smaller number of deliverables which are better aligned to SOs, the delivery of those will not routinely provide assurance that SOs are being achieved - we need some strategic outcome focused statements.
- Culture
- System collaboration and integration
- ROI & benefits realisation of CMT and APF
- Board could have a particular focus on one strategic area at each meeting
- Future Employee satisfaction

Q3: What one improvement to committee escalations or governance flow would most strengthen board assurance?

- Concise reporting by committee chairs to full board
- Committee focusing the majority of their meetings on strategic delivery, risks, outcomes and learning, with the board receiving the full picture on strategic delivery, risks and outcomes in a digestible form.
- Clearer and more direct language use in terms of the nature of the issue and the action required by the Board
- Committee's spend time in operational detail and having a strategic BAF and then focusing agenda's on the delivery of strategy and mitigation of risk would be useful. Board packs are too long and repetitive and could be more focused
- Automated data reporting and visualisation at strategic level with opportunity for segmented drill down
- The cadence of meetings and therefore the timeliness of reporting (with there often being a gap between Committees and Board meetings).
- Need to avoid duplication. FPC can feel like a rehearsal for Trust board and clarity of the boundaries of each would provide more efficient governance. Some matters e.g. finance could spend less time in FPC and more in TB as it is often repetitious.
- Improved flow of KPIs with board focus on strategic indicators and committee focus on delegated remits (in progress)
- Time to discuss the issue being escalated

Q4: If you were chair for a day, what is the single most important improvement you would make to the board?

- Focus our agenda more on the primary role of the Board, which is strategic development, delivery, risks and outcomes. Also a focus on how we are influencing the system, working with a new government and horizon-scanning at levels 2 and 3, more than level 1.
- Recalibrate some of the agenda to be more strategic/future-focused (horizon-scanning)
- There are too many pages in Committee and Trust Board papers. There is a need to strip back papers so that real matters receive the focus.
- Being able to answer the question - how can we measure the improvements and offer assurance that the actions we are taking will mitigate risks and deliver patient improvements
- Ensuring the most appropriate balance of strategic assurance and reporting against the capacity of the organisation to generate content
- Greater focus on delivery of organisational strategy, with appropriate alignment of plans and metrics across the organisation to support it in discharging its duties. The board agendas and operations would then change to reflect this shift in focus.
- Allocate real time for horizon scanning both of the NHS system (Wales and UK) and the societal changes that are evolving over the next 5 years.
- Allow sufficient time for discussions and assurance, meetings can often feel quite rushed - not just TB but some of the Committees too
- More time on bringing together NEDs and Directors

- Increase strategic focus to inform longer term strategic priorities.
- Determine what the purpose of board development sessions really is.
- Fully align Board members' skills & experience to Chair roles
- Actively seek broader opinion from participants
- More time for strategic conversations.

A bespoke WAST maturity matrix

The board maturity matrix is intended as a practical tool to support collective reflection and development. Boards typically derive most value when it is used in a facilitated session, allowing members to discuss and agree where they believe the organisation sits across each dimension.

This can be undertaken either through a structured board development session or via a short survey approach (e.g. MS Forms), with results then discussed collectively.

It is recommended that the matrix is revisited annually as part of the board effectiveness cycle, enabling the board to track its development over time and identify priority areas for focus.

WAST board effectiveness maturity matrix

A maturity matrix to support development and improvement

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

Progress levels / Key elements	1 BASIC LEVEL – PRINCIPLE ACCEPTED AND COMMITED TO ACTION	2 EARLY PROGRESS – IN DEVELOPMENT	3 FIRM PROGRESS – IN DEVELOPMENT	4 RESULTS BEING ACHIEVED	5 MATURITY – COMPREHENSIVE ASSURANCE IN PLACE	6 EXEMPLAR
Reset committee structures and ways of working	Agreement to review committee purpose, structure and duplication; initial mapping of current committees and reporting lines	Revised committee terms of reference drafted; duplication reduced; clearer forward plans introduced	Committee structure streamlined and aligned to strategic priorities; consistent agenda discipline and reporting formats embedded	Committees demonstrably add value, with improved decision-making, reduced cycle time and clearer escalation routes	Committees operate as an integrated system supporting Board assurance and strategy, with regular review of effectiveness	Committee model recognised as sector-leading; routinely adapted in response to organisational need and shared externally as best practice
Re-anchor strategy as the primary organising principle for the Board	Shared agreement that Board focus should shift toward strategy; gaps identified between strategy and current agendas	Board agenda and cycle redesigned to prioritise strategy; initial alignment of papers to strategic objectives	Strategy consistently drives Board and committee work; decisions explicitly linked to strategic intent	Clear line of sight between strategy, delivery and outcomes; Board actively shapes and challenges strategic direction	Strategy is dynamic, regularly refreshed, and clearly understood across the organisation; Board role in stewardship is well established	Organisation recognised for clarity of strategic governance; Board seen as a strategic asset influencing wider system direction
Improve the quality of insight and reporting	Recognition of inconsistency and volume issues in reporting; initial agreement on need for improvement	Standardised reporting templates introduced; focus on reducing volume and improving clarity	Reports provide clearer insight, trends and risks; reduced reliance on narrative-only reporting	Board receives high-quality, actionable insight enabling better scrutiny and decision-making	Insight is predictive, integrates qualitative and quantitative data, and supports forward-looking governance	Reporting approach seen as best practice; organisation widely recognised for high-quality, insight-led governance
Simplify and strengthen assurance routes below ELT	Mapping of current assurance landscape completed; duplication and gaps identified	Clearer assurance framework designed; initial rationalisation of groups and reporting lines below ELT	Assurance routes streamlined, with defined ownership, escalation points and reduced duplication	Board and ELT receive coherent, reliable assurance; risks are escalated appropriately and in a timely way	Assurance is systematic, proportionate and trusted; clear 'golden thread' from frontline to Board	Assurance framework is highly effective and externally recognised; approach informs wider system practice
Strengthen capability in digital, data and future readiness	Acknowledgement of capability gaps in digital, data and horizon scanning; initial assessment undertaken	Acknowledgement of capability gaps in digital, data and horizon scanning; initial assessment undertaken	Improved capability evidenced in decision-making and operational delivery; data increasingly informs strategy	Digital and data capabilities actively drive performance improvement and innovation	Organisation consistently anticipates future challenges and adapts using strong digital and analytical capability	A clear leader in digital and data-enabled governance; contributing to, and shaping, system-wide innovation and learning
Create protected space for strategic thinking and board development	Agreement on need for dedicated Board development and strategic time; initial planning underway	Regular Board development sessions introduced; some protected time for strategic discussion established	Strategic sessions are structured, high-quality and well attended; Board development linked to organisational needs	Board demonstrates improved cohesion, capability and quality of strategic discussion	Continuous Board development embedded; reflective practice and learning culture well established	Board recognised for high performance and self-improvement; approach to development shared as leading practice

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Recommendation	Action No.	Action	Improvement objective	Measure of success	Target Date	RAG	Lead
Priority area 1: Reset committee structures and ways of working **Maturity level Q2 2026/27:** Level 1: agreement to review committee purpose, structure and duplication; initial mapping of current committees and reporting lines **Maturity level Q3 2027/28:** Level 3: committee structure streamlined and aligned to strategic priorities; consistent agenda discipline and reporting formats embedded							
Align all board and committee discussions to a set of clear straetgic objectives and outcomes (R2). Redesign agendas to focus on key strategic risks and decisions (R14).	1.1	Align SOs to each committee	Board knows the strategic direction and consistently uses it to guide decisions, trade offs and prioritisation.	Each SO is overseen by the board or a committee (note this has been agreed and will be in place for Q2 IMTP reporting. FPC = SO1, 3 and 6; QUEST = SO5; PCC = SO2; with board retaining SO4)	Complete	Complete	Deputy CEO
	1.2	Committee terms of reference and agenda are revised to align to the agreed strategic objectives and IMTP reporting is provided to those committees for each SO	Board knows the strategic direction and consistently uses it to guide decisions, trade offs and prioritisation.	Terms of reference already provide for FPC, QUEST and PCC to oversee strategic development and delivery and this will be strengthened as they are revised in Q4 2026/27 Q2 committee reporting will provide IMTP delivery for the SOs that FPC, QUEST and PCC are responsible for.	25 March 2027	On track	Director of Corporate Governance
	1.3	ARAC to endorse and board to agree a strategic reporting and assurance framework for board committees	Simplify, clarify and rebalance the committee agendas to they provide assurance more effectively while freeing up space for strategic leadership	Agreed framework	24 September 2026	On track	Director of Corporate Governance
Undertake a fundamental review of committee purpose and structure (R13).	1.4	Implementation of the recommendations made by ARAC to board in January 2026 to streamline committees: reduce committees from seven to six (by disbanding APC), with each committee to have four NEDs and a quorum of three. Resilience, cyber and IG from FPC to ARAC; FPC to take research, innovation and partnership trilogy)	Alignment of committee remits more closely to the SOs; Improve efficiency and effectiveness of governance; Reduce meeting frequency, alleviating quorum/NED availability pressures; Ensure strong scrutiny, challenge and support through increased NED attendance on key committees	Terms of reference approved	25 March 2027	On track	Director of Corporate Governance
	1.5	Reduce Charity Committee and Corporate Trustee meetings from four a year to two a year given the revised approach to the charity from August 2026	As above	Terms of reference approved reflecting meeting frequency and change of approach to charity	25 March 2027	On track	Director of Corporate Governance
	1.6	New chair to agree the revised quoracy proposed in the ARAC paper to the board in discussions with NEDs.	As above	Terms of reference approved reflecting revised quoracy	25 March 2027	Not started	Director of Corporate Governance
	1.7	Consider a revised sequencing of quarterly committee meetings to align to quarterly IMTP strategic delivery reporting to board	Reduce complexity and increase efficiency	Consideration of approach by ARAC	24 June 2027	Not started	Director of Corporate Governance
Priority area 2: Re-anchor strategy as the primary organising principle for the board (to support clearer lines of sight between purpose, delivery and impact) **Maturity level Q2 2026/27:** Level 1: Shared agreement that board focus should shift toward strategy; gaps identified between strategy and current agendas **Maturity level Q3 2027/28:** Level 3: Strategy consistently drives board and committee work; decisions explicitly linked to strategic intent							
Position strategy explicitly as the primary framework for board agendas and decision-making (R1).	2.1	ARAC to endorse and board to approve revised approach to board agenda to allow for a balance of strategy assurance aligned to IMTP delivery, and deep dives/horizon scanning on issues arising	Board knows the strategic direction and consistently uses it to guide decisions, trade offs and prioritisation.	Four meetings a year receive the IMTP report showing delivery of strategic objectives, the MIQPR showing outcomes linked to delivery, and the BAF showing risks to strategic objectives. Two meetings a year provide space for deep dives, horizon scanning, prioritisation	24 September 2026	On track	Director of Corporate Governance
	2.2	Revised IMTP board reporting focuses on SO delivery with overarching dashboard for the board and more detailed delivery for committees	Discussions are shaped less by immediate operational pressures, and more around strategic priorities, outcomes and risks	Reporting in place	26 November 2026	On track	Deputy CEO
	2.3	Revised MIQPR board reporting focuses on SO outcomes for the board via the MIQPR dashboard, and more detailed metrics for committees	Discussions are shaped less by immediate operational pressures, and and more around strategic priorities, outcomes and risks	Reporting in place, noting there will be iterations of the MIQPR for the committees during 2026/27 and annual revisions in line with outcomes expected from the IMTP deliverables related to each SO]	Complete	Complete	Deputy CEO
	2.4	Revised BAF board reporting focused on SO risks rather than principle risks	Discussions are shaped less by immediate operational pressures, and more around strategic priorities, outcomes and risks	The board is able to see the risks to each SO, whether they are within tolerance of its set risk appetite, and the strength of controls and assurance. The first BAF risk will be SO2, and others will follow, noting however that each principle risk is mapped to each SO currently.	27 May 2027	On track	Director of Corporate Governance
	2.5	Update guidance on presentation of AAAs from committee chairs focussing on key areas of SO delivery, outcomes and risk	Distinguish between general oversight, and those issues the require focused attention and decisions.	Updated guidance	15 November 2026	Not started	Director of Corporate Governance
	2.6	Chairs focussing on drawing out key areas of SO delivery, outcomes and risk from AAAs (applying guidance)	Distinguish between general oversight, and those issues the require focused attention and decisions.	Chairs applying that guidance over two quarters	01 April 2027	Not started	Chairs of committees
Strengthen the consistency and effectiveness of challenge (R9). Sharper challenge in this context means: (a) linking questions explicitly to strategic objectives and outcomes (b) testing underlying assumptions and use of evidence (c) maintaining focus on areas of greatest risk or impact (d) ensuring clarity on what decisions or actions are required	2.7	Update board resources (including a stand alone board Siren page) and provide a board development session on scrutiny, particularly once the new form of agenda is embedded.	Awareness that collegiality and mutual respect between NEDs and executives can temper the effectiveness of challenge, especially on complex or system-wide issues	Board development session delivered and resources updated	30 June 2027	Not started	Director of Corporate Governance
Establish clearer governance of digital and innovation (R21). Improve board visibility of digital strategy and investment (R22). Build confidence and literacy in digital issues (R23).	2.8	Refreshed strategic DDAT KPI/reporting framework introduced for FPC	Development of a more coherent view of risk, opportunity and investment in these areas	Presentation and approval of reporting framework	18 May 2027	On track	Director of Digital Services
	2.9	Establishment of the digital delivery group and sub-groups (DDAT) providing a more coherent view of investment, prioritisation and benefits realisation	Provides confidence of effectiveness of delivery group as the primary vehicle through which the board receives assurance	Terms of reference for DDAT and all sub-groups approved (focus from August to May on embedding the digital oversight group (DOG))	01 May 2027	On track	Director of Digital Services

Key:

- On Track
- Action Required/Caution
- Monitor
- Caution
- Paused
- Not Started
- Complete

Priority area 3: Improve the quality of insight and reporting (to shift the emphasis of reporting from volume and data to clarity of insight) **Maturity level Q2 2026/27:** Level 1: Recognition of inconsistency and volume issues in reporting; initial agreement on need for improvement **Maturity level Q3 2027/28:** Level 2: Standardised reporting templates introduced; focus on reducing volume and improving clarity							
Develop a more integrated narrative linking performance, finance, workforce and patient outcomes (R3). Refocus reporting on insight, trends and implications (R17). Strengthen analysis of causation and forward risk (R18). Integrate reporting across quality, performance and workforce (R19). Increase emphasis on learning and improvement actions (R20).	3.1	Update board and committee writing and presentation guidance to more clearly set out the expectation for analysis	Strengthening the translation of data into meaningful analysis, trends and actionable intelligence will materially improve the quality of discussion and decision-making	Updated guidance published on Siren and provided to key report writers, noting the action above that the MIQPR will iterate for committee specific reporting ahead of the next IMTP	31 December 2026	Not started	Director of Corporate Governance
	3.2	Central ownership/operating model for integrated performance and insight	Strengthening the translation of data into meaningful analysis, trends and actionable intelligence will materially improve the quality of discussion and decision-making	Model agreed by ELT	01 November 2027	On track	DCEO and Director of Digital Services
Priority area 4: Simplify and strengthen assurance routes below ELT **Maturity level Q2 2026/27:** N/A **Maturity level Q3 2027/28:** Level 1: mapping of current assurance landscape completed; duplication and gaps identified							
Simplify assurance routes and clarify escalation pathways (R15). Strengthen governance below ELT to improve confidence and reduce reporting burden (R16).	4.1	The ELT has established a task and finish group to progress the development of delivery groups, focusing on defining clear measures of success and implementation timelines, assessing the benefits, opportunities, risks, challenges and resource requirements, identifying potential pilot or early adopter groups, exploring opportunities to repurpose or transition existing forums into the new model, ensuring that quality remains central to the programme, and considering the organisational change required to support successful implementation. The task and finish group will close in October and report to ELT in November with recommendations. Thereafter the actions for priority area 4 will be updated and reported to ARAC.	Simplified governance arrangements and strengthening confidence in assurance routes will reduce unnecessary burden and sharpen focus at board level	Actions to address priority area 4 agreed with ELT and reported to ARAC. NB: Work will progress on establishing early adopters and reviews of extant groups whilst this work is progressing.	04 March 2027	On track	Director of Corporate Governance
Priority area 5: Build on the development of the board skill matrix to identify and activity mitigate priority gaps (and identify ongoing capability development) **Maturity level Q2 2026/27:** Level 1: Acknowledgement of strategic capability gaps in digital, data and horizon scanning; initial assessment undertaken **Maturity level Q3 2027/28:** Level 2: Digital, data and future-readiness priorities agreed; capability development plans in place and horizon scanning begins to inform Board discussions							
Agree a clear statement of priority board capabilities (R5).	5.1	ARAC sub-group to review the revised board skills matrix and identify gaps of priority board capabilities	Increased ability to confidently challenge on future-facing issues	Gaps identified and communicated to the Trust Board Chair	29 September 2026	On track	Director of Corporate Governance
Implement a targeted development programme focusing on digital, data and system working (R6). Increase exposure to innovation and emerging service models (R8).	5.2	In conjunction with the new Trust Board Chair, develop a refreshed approach to board development which addresses identified gaps	Increased board confidence of emerging technologies, digital capability, data-driven decision-making and system working.	Refreshed board development programme	27 May 2027	Not started	Director of Corporate Governance
Consider use of external advisers or panels to strengthen oversight (R7).	5.3	The issue of external advisors for oversight to be discussed with the new Trust Board Chair, noting the potential cost implications		Decision on external advisors	27 May 2027	Not started	Director of Corporate Governance
	5.4	Gartner maturity and AI ambition session at board development	Increased board confidence of emerging technologies, digital capability, data-driven decision-making and system working.	Session held	01 December 2026	On track	Director of Digital Services
Priority area 6: Create protected space for strategic thinking and board development (to transition from a predominately operational focus to more balanced) **Maturity level Q2 2026/27:** Level 1: Agreement on need for dedicated board development and strategic time; initial planning underway **Maturity level Q3 2027/28:** Level 3: strategic sessions are structured, high-quality and well attended; board development linked to organisational needs							
Clarify the board's ambition in relation to system leadership (R10). Be explicit about areas of influence and control (R11).	6.1	In the development of the next long term strategy, the board's ambition and the appetite of partners in respect of system leadership will be drawn	Opportunity for the board define more explicitly how it will act as a leader within he wider system - shaping, influencing and, where necessary, challenging the environment in which it operates	TBC	01 December 2027	Not started	Deputy CEO and Director of Partnerships and Engagement
Use external perspectives to test assumptions and stretch thinking (R12).	6.2	The CEO shares external perspectives in board and other meetings, however NEDs are encouraged to do likewise when attending All Wales Peer Groups. NEDs are invited to share the agenda of those groups ahead of the meeting to enable the executives to support with key messages.	Strengthens scrutiny with the wider system impact, influence and contribution in mind	Ongoing throughout the year with check in for effectiveness of approach in June	30 June 2027	Not started	Director of Partnerships and Engagement

NB: Recommendations 24-28 are being treated as outcomes and benefit of the actions set out above, rather than stand alone actions to avoid duplication

WAST board effectiveness maturity matrix

A maturity matrix to support development and improvement

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
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Simplify and strengthen assurance routes below ELT	Mapping of current assurance landscape completed; duplication and gaps identified	Clearer assurance framework designed; initial rationalisation of groups and reporting lines below ELT	Assurance routes streamlined, with defined ownership, escalation points and reduced duplication	Board and ELT receive coherent, reliable assurance; risks are escalated appropriately and in a timely way	Assurance is systematic, proportionate and trusted; clear 'golden thread' from frontline to Board	Assurance framework is highly effective and externally recognised; approach informs wider system practice
Strengthen capability in digital, data and future readiness	Acknowledgement of capability gaps in digital, data and horizon scanning; initial assessment undertaken	Digital, data and future-readiness priorities agreed; capability development plans in place and horizon scanning begins to inform Board discussions.	Improved capability evidenced in decision-making and operational delivery; data increasingly informs strategy	Digital and data capabilities actively drive performance improvement and innovation	Organisation consistently anticipates future challenges and adapts using strong digital and analytical capability	A clear leader in digital and data-enabled governance; contributing to, and shaping, system-wide innovation and learning
Create protected space for strategic thinking and board development	Agreement on need for dedicated Board development and strategic time; initial planning underway	Regular Board development sessions introduced; some protected time for strategic discussion established	Strategic sessions are structured, high-quality and well attended; Board development linked to organisational needs	Board demonstrates improved cohesion, capability and quality of strategic discussion	Continuous Board development embedded; reflective practice and learning culture well established	Board recognised for high performance and self-improvement; approach to development shared as leading practice

A Strategic Reporting and Assurance Framework for Board Committees

Purpose: To establish a common framework to guide how board committees receive assurance, beyond core strategic objectives, risks, and outcome-focused KPIs. Its aim is to ensure committee reporting is strategic, risk-based, and proportionate, while enabling the board to discharge its statutory, regulatory, and stewardship responsibilities.

The framework supports a consistent approach across committees, while allowing flexibility to reflect differing remits.

Core Principle: The committee's primary focus is assurance over delivery of the strategic objectives within its remit. Any additional information requested should demonstrably support the committee's ability to advise the Board on delivery, risk, compliance, or organisational resilience, rather than provide operational oversight.

The Strategic Reporting Framework

Committees should expect reporting to fall into five interrelated assurance domains. Items brought to committee should clearly align to at least one or more domains.

1. Strategic Delivery and Outcomes (Primary focus)

Committees oversee:

- progress in delivering the strategic objectives within their remit
- the outcomes expected from planned actions with clear insights, analysis and trends
- the strategic risks to delivery and effectiveness of mitigation..

Reporting should focus on whether the strategy is on track, whether actions are likely to deliver intended outcomes, and whether material risks are being managed within appetite.

2. Risk, Control, and Early Warning

The governance framework should enable committees to receive information that:

- provides early warning of potential threats to strategic delivery/system or partnership concerns
- allows assessment of control effectiveness
- highlights emerging risks not yet reflected in performance outcomes
- covers the relevant NHS Wales Operating and Accountability framework pillars

This may include control assurance reports (audit etc), issues escalated from delivery groups and ELT, and trend data where deterioration would indicate future strategic impact.

3. Statutory, Regulatory, and Legal Compliance

Committees should assure the board that:

- statutory and regulatory duties within their remit are being met
- material non-compliance is identified, understood, and managed

- emerging legislative or regulatory changes are being addressed

Reporting should confirm level of compliance and exposure, risks associated with non-compliance, adequacy of assurance. Detailed compliance monitoring should be limited to exception reporting where risk is elevated.

4. Organisational Sustainability and Capacity

Committees should consider a limited set of indicators that test whether the Trust has the capacity, capability, and resilience to deliver future strategy.

This may include:

- workforce sustainability and capability
- financial resilience
- infrastructure, digital, fleet, or estates readiness
- emergency preparedness

The purpose is assurance over future delivery, not assurance over day-to-day management.

5. Learning, Improvement, and Change

Committees should assure the board that:

- learning from incidents, feedback, and reviews is embedded
- major improvement or transformation programmes are deliverable
- benefits are being realised and risks managed

Reporting should focus on themes, learning, and impact, rather than volume or individual cases.

Supporting Governance Principles

Across all five domains, the following principles apply:

- Focus on value: agendas should be structured around decision-making, assurance and learning, rather than comprehensive reporting
- Clarity of purpose: each committee should have a clearly defined role aligned to strategic priorities and key risks
- Avoidance of duplication: responsibilities should be clearly delineated to reduce repetition between committees and the board
- Alignment to assurance flows: committee structures should support a clear and coherent pathway from operational risk to board level assurance

Agenda Item No.	08

REPORT TITLE

Risk Management and Board Assurance Framework Report

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	03 September 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 12 August 2026.

4. The report highlights the inclusion of three new risks:

    a. Risk 700 *Failure to implement and deliver the statutory requirements of the revised Concerns Regulations and accompanying 'Listening to People' Guidance* at a score of 16 (4x4)
    b. Risk 706 *The Trust's inability to maintain preparedness for a pandemic response causing patient harm and death at a score of 15* (3x5)
    c. Risk 708 *Failure to secure timely access to patients in locked or inaccessible premises due to unclear inter agency responsibilities and absence of enforceable escalation arrangements* which was approved for inclusion at a score of 20 (5x4) but was subsequently reduced to a score of 8 (2x4) due to interim controls implemented.

High Level Summary of the 2026/27 Work Programme and Progress

5. Progress in delivering the next phase of the risk management programme for 2026/27 is positive, with development of the following:
    a. Design and development of the new ERM
    b. Strategic risk aligned to strategic objective 2
    c. Strategic BAF template and BAF dashboard for Board level reporting
    d. Suite of strategic risks aligned to strategic objectives
    e. Thresholds and tolerances aligned to the suite of risk appetite statements
    f. Principal risks mapped to strategic objectives

6. Outputs from this work were considered by the sub group of the Audit, Risk and Assurance Committee subgroup on 15 August 2026, and endorsement for the proposed direction of travel will be sought from the ELT on 26 August 2026. A dedicated risk management session is planned for the Board Development Day on 17 December 2026.

7. 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:

1. Consider and note the direction of travel for the Trust's risk management programme for 2026/27, including the design and development of a new risk management system, the new strategic Board Assurance Framework and enhancement of risk reporting arrangements;

2. 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

3. Note the inclusion of three new risks on the corporate risk register: Risks 700, 706 and 708 as detailed in the paper.

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
12 August 2026	Executive Leadership Team

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, oversight of the strategic BAF, 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

7. At its meeting in March 2026, the committee agreed the priorities for the next phase of the risk management programme.

8. Good progress has been made during the reporting period in developing the key components of the Trust's future risk management and assurance framework, including:

- Design and development of the new Electronic Risk Management (ERM) system
- Development of a strategic Board Assurance Framework (BAF)
- Development of a strategic BAF template
- Development of a BAF dashboard for Board level reporting
- Development of a suite of strategic risks aligned to strategic objectives
- Development of thresholds and tolerances aligned to the Trust's approved Risk Appetite Statements
- Mapping of principal risks to strategic objectives

9. Outputs from this work were considered by the ARAC Sub-Group in August 2026, providing valuable challenge and feedback to inform the next phase of development, discussion with the ELT will take place in early September 2026 to endorse the direction of travel, with a board development session on 17 December 2026.

10. The strategic BAF, overarching board dashboard and suite of associated strategic risks are expected to be implemented towards the end of quarter 3. The piloting of the ERM with the Corporate Governance and People Services risks is expected in September 2026.

11. Work will continue with additional focus on:

- 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
- Refinement of the strategic risk methodology and reporting arrangements
- Finalisation of strategic risks aligned to strategic objectives
- Development of guidance and training materials to support implementation of the new ERM and training more generally across the organisation to support effective risk management

12. Delivery continues to be managed through defined milestones, governance and reporting arrangements within the Corporate Governance Local Delivery Plan.

13. Taken together, this work represents a significant step towards a more integrated and strategically focused approach to risk management and assurance, strengthening oversight, transparency and decision-making across the Trust.

Risk Appetite Statements

14. The suite of Risk Appetite Statements, approved by the Board in November 2025, is scheduled for annual review during autumn 2026; however, this will take place later in the year to align with the other elements of the risk management work programme. The review will consider whether the statements remain appropriate considering the Trust's evolving risk profile and strategic priorities.

15. Initial discussions have identified opportunities to strengthen the framework further, including consideration of appetite levels and whether additional coverage is required for areas such as cyber security and the use of artificial intelligence technologies.

16. 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

17. The Trust has continued to progress the design and development of a new Enterprise Risk Management (ERM). This new system will be ready to pilot in September 2026 with the Corporate Governance and People & Culture directorate risks.

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 12 August 2026 having considered the review of each risk undertaken throughout the period by risk owners.

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 and which is included in the Reading Room. 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. Members will note that the score for Risks 223 and 224 have 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. This score represents 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. The Trust cannot fully mitigate the scale of handover lost hours due to the wider system environment.

26. 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.

27. The risks are reflected in the patient harm dashboard which will be presented to the Quality, Patient Experience and Safety Committee (QuEST) going forward, as agreed at the board meeting in March 2026. Both risks have continued to be reviewed at each committee with the Agenda items reflecting the controls and mitigations discussed throughout the meeting. These risks continue to be escalated to the board via the meeting's AAA report.

28. Members are asked to note that three new risks were approved for inclusion in the corporate risk register in the last review as follows:

    a) **Risk 700** *Failure to implement and deliver the statutory requirements of the revised Concerns Regulations and accompanying 'Listening to People' Guidance* at a score of 16 (4x4).

    b) **Risk 706** *The Trust's inability to maintain preparedness for a pandemic response causing patient harm and death at a score of 15* (3x5)

    c) **Risk 708** *Failure to secure timely access to patients in locked or inaccessible premises due to unclear inter agency responsibilities and absence of enforceable escalation arrangements* which was approved for inclusion at a score of 20 (5x4) but was subsequently reduced to a score of 8 (2x4) due to the introduction of interim controls, with the expectation that this score would be reviewed should permanent arrangements not be secured.

29. **Risk 201a** *Relationships with Stakeholders* and **Risk 201b** *Poor Patient Experience Affecting Reputation* remain static at a score of 16 (4x4) with scores being kept under review. Both risks will be considered by the board at its September 2026 meeting given their overarching reputational nature.

30. **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 21 July 2026.

31. **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.

32. **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.

33. **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 discussed by the FPC in July 2026 with agreement that this would be removed from the BAF extract until later in the financial year whilst work is undertaken on the disaggregated elements of the risk. Members noted that while the risk retains its high score, mitigation continues to be constrained by capacity limitations.

34. **Risk 671** *Unauthorised or Inappropriate use of AI technologies* and **Risk 690** *SAR and Disclosure of Records Compliance* remain static at a score of 16 (4x4) in this review period despite a potential reduction in score being discussed by the ELT.

35. **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.

36. **Risk 139** *Failure to Deliver our Statutory Financial Duties* remains static at a score of 12 (3x4) in line with the financial position for 2026/27.

37. **Risk 100** *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* – Members are asked to note that the ELT considered proposals to reframe the risk to focus on the commissioning and contractual framework, including clear expectations, accountability and funding arrangements, and the associated impact on the delivery of safe and effective services. The detail of this will be presented at a later meeting.

38. **Risk 163** *Maintaining Effective & Strong Trade Union Partnerships* remains unchanged at a score of 12 (3x4) in this review period.

Risk Trending Data

39. A dashboard describing principal risk score trends from March 2023 and their movement over time has been produced and is attached at Annex 5.

40. 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.

41. Risks that have achieved their target score and are considered stable are no longer routinely reported to ARAC, enabling greater focus on areas where risk exposure has changed or where progress remains limited.

42. Members will note that a limited number of risks have recorded changes in score over a significant period, with the majority remaining static despite ongoing mitigating actions being taken and articulated.

43. The lack of movement across several risks warrants further consideration, as this may indicate that planned actions are either not being implemented as intended or are not delivering the anticipated reduction in risk exposure. This issue will be explored further through Executive Leadership Team discussions in October 2026. The introduction of risk tolerance thresholds linked to Board approved risk appetite will also provide a more sophisticated means of assessing the effectiveness of controls and mitigations, enabling future reporting to focus not only on changes in risk scores but also on whether risks remain within acceptable levels of exposure.

44. Risks 160 and 558 have been incorporated within a newly established risk to better reflect the nature of the exposure and avoid duplication. In addition, the articulation and categorisation of the Decarbonisation risk is currently under review to ensure it remains appropriately articulated within the Corporate Risk Register.

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 28 October 2026 for discussion and approval of the activity.

49. The ELT will consider the outputs associated with the direction of travel for the risk management programme on 26 August 2026 with a focused session planned for the next Board Development Day on 17 December 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)** →
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	Chief Clinical Officer	**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 Manchester Arena	**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**
	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)** →
201b Trust Board	Poor Patient Experience Affecting Organisational Reputation	**IF** a patient receives a poor experience from the Trust; the Trust receives negative regulatory reports or adverse media scrutiny **THEN** there is a risk that public confidence in the organisation may decline and scrutiny from regulators and oversight bodies may intensify **RESULTING IN** reputational damage that undermines confidence in the Trust's ability to deliver safe,	Chief Clinical Officer	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		high-quality care and achieve its strategic objectives		
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	Chief People Officer	**16 (4x4)** →
690 FPC	SAR and Disclosure of Records Compliance	**IF** records requests from patients, the public or staff are not processed consistently, correctly or in a timely manner **THEN** inappropriate withholding of information or disclosures may occur, and statutory timeframes may not be met	Director of Digital	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN non-compliance with UK GDPR requirements, possible financial penalty, data breaches, and complaints causing negative patient or staff impact and reputational damage		
NEW 700 QuEST	Failure to implement and deliver the statutory requirements of the revised Concerns Regulations and accompanying 'Listening to People' Guidance.	**IF** The Trust is unable to sustainably reduce and manage the current concerns backlog whilst implementing and meeting the statutory requirements of the revised Concerns Regulations and associated Listening to People Guidance **THEN** The Trust is unable to meet its statutory and regulatory obligations or demonstrate effective quality governance, organisational learning and improvement **RESULTING IN** Regulatory escalation, increased external scrutiny, reputational and financial impacts, reduced confidence among patients, staff, partners and regulators, poorer patient and staff experience, and missed opportunities to learn and improve.	Chief Clinical Officer	**16 (4x4)**
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	Executive Director of Operations	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		responder under the Civil Contingency Act 2004.		
NEW 706 QuEST	The Trust's inability to maintain preparedness for a pandemic response causing patient harm and death	**IF** the Trust is unable to maintain preparedness for a response to a pandemic **THEN** there is a risk of inability to respond to patients in the community **RESULTING IN** patient harm and death.	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	Deputy Chief Executive	**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) **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)	Executive Director of Finance & Corporate Resources	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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	Chief People Officer	**12 (4x3)** →
NEW 708 QuEST	Failure to secure timely access to patients in locked or inaccessible premises due to unclear inter agency responsibilities and absence of enforceable escalation arrangements	**IF** there is inconsistent inter agency agreement, mobilisation behaviour, and escalation arrangements between Ambulance, Police and Fire & Rescue Services regarding responsibility for gaining entry to premises, including variability arising from the application of the 'Right Care, Right Person' initiative beyond mental health presentations, and no consistently enforceable mechanism to resolve disputed agency responsibility at scene **THEN** there is a risk of delay or failure in gaining timely access to patients in locked or inaccessible properties, leaving ambulance crews unable to provide welfare or clinical assessment or treatment despite reasonable belief of risk to life,	Executive Director of Operations	**8 (2x4)** ↓ **20 (5x4)**

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN delayed clinical assessment and treatment, inability to confirm patient welfare, patient deterioration or death, increased serious incidents, coronial and regulatory scrutiny, moral injury and professional risk to staff, legal and reputational risk to the Trust, and unsafe expectations being placed on ambulance staff who do not hold statutory powers of entry.		

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

Committee	Directorate	Risk ID	Risk Title	Strategic Objective	Risk Appetite	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	Aug-26	Risk ID
QSPE	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	25	223
QSPE	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	25	224
FPC	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	20	260
FPC	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 casualty incident	1	Open				20	20	20	20	20	20	20	20	20	20	20	20	641
PCC	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
FPC	Digital Services	671	Unauthorised or inappropriate use of AI technologies	3	Keen							16	16	16	16	16	16	16	16	16	671
FPC	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	16	542
Trust Board	Partnership and Engagement	201a	Relationships with Stakeholders	5	Open									16	16	16	16	16	16	16	201a
Trust Board	Quality & Nursing	201b	Poor Patient Experience Affecting Reputation	4	Open									16	16	16	16	16	16	16	201b
QSPE	Quality & Nursing	706	The Trust's inability to maintain preparedness for a pandemic response causing patient harm and death	1	Open															16	706
QSPE	Quality & Nursing	700	Failure to implement and deliver the statutory requirements of the revised Concerns Regulations and accompanying 'Listening to People' Guidance.	1	Open															15	700
PCC	People & Culture	680	Deteriorating Employee Experience and Workforce Capacity due to underinvestment in people and organisational culture	4	Open													16	16	16	680
FPC	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	15	594
PCC	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
QSPE	Digital Services	620	Symptom Checkers	1	Open				20	15	15	15	15	15	15	15	15	15	15	15	620
FPC	Digital Services	690	SAR and Disclosure of Records Compliance	3	Keen													16	16	16	690
PCC	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	12	163
FPC	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	12	100
FPC	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	12	139

QSPE	Quality & Nursing	708	Failure to secure timely access to patients in locked or inaccessible premises due to unclear inter agency responsibilities and absence of enforceable escalation arrangements	1	Open															8	708
PCC	Partnership and Engagement	201	Damage to Trust reputation following a loss of stakeholder confidence			20	20	20	20	20	20	20	20								201
FPC	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
PCC	People & Culture	557	Potential impact on services as a result of Industrial Action																		557
FPC	Digital Services	543	Major disruptive incident resulting in a loss of critical IT systems			10															543
PCC	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
FPC	Finance and Corporate Resources	244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service																		244
FPC	Strategy, Planning & Performance	424	Prioritisation or Availability of Resources to Deliver the Trust's IMTP			12	8														424
FPC	Operations	283	Failure to implement the EMS Operational Transformation Programme																		283
FPC	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

Agenda Item No.	09

REPORT TITLE

Policy Governance Update (six-monthly report)

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	03 September 2026
Public or Private	Public
If private - rationale	Choose item from below

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 with a six-monthly update on policy governance arrangements, progress against the 2026/27 Policy Work Programme and the status of the management action arising from the 2025 Audit Wales Structured Assessment recommendation relating to policy governance.

2. Since the previous update, scoping work has been undertaken in relation to the proposed Policy Transformation Programme which was the management action for the Structured Assessment recommendation. This activity confirmed that, to be truly effective, delivery of the original management action would require a significant organisation-wide programme of work extending beyond policies to include the review and rationalisation of a broad range of written control documents. Taking account of current organisational capacity and the level of residual risk, it is proposed that the original management action be amended to focus on strengthening policy governance arrangements through the development of revised policy templates, approval processes and supporting policy. This approach is intended to streamline policy management arrangements and improve the currency of Trust policies.

3. The report also provides an update on delivery of the 2026/27 Policy Work Programme, which was approved by the Executive Leadership Team in July 2026 and is overseen through the Trust's Policy Group. As at 19 August 2026, 63% of Trust-owned policies were within review-date compliance, representing a continued improvement from the position reported in August 2025. Progress continues to be monitored through established governance arrangements, with regular reporting to the Executive Leadership Team.

4. Overall, the report provides reasonable assurance that appropriate governance, oversight and prioritisation arrangements are in place to support continued improvement in policy compliance and policy governance. Whilst the Structured Assessment management action is being revised to reflect organisational capacity and a proportionate assessment of risk, there is evidence of sustained improvement in policy governance, strengthened executive oversight and a clear programme of work to address outstanding priority policies.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Audit, Risk and Assurance Committee is requested to:

1. **Note** the revised management action for the Audit Wales 2025 Structured Assessment audit action;

2. **Note** progress against the 2026/27 Policy Work Programme (as at 19 August 2026); and

3. **Receive** assurance regarding the planned approach regarding those policies which remain outstanding, to bring them within review date compliance.

ADDITIONAL PAPER(S)

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

n/a

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

Corporate Governance Directorate Risk

IF Trust-owned policies are not reviewed and submitted for approval in a timely manner

THEN the Trust cannot be assured that its' policies are up-to-date and appropriate

RESULTING IN management actions and decisions being made based on out-of-date guidance, staff not being aware of updated legislation, procedures or practices, the potential of adverse outcomes for patients in relation to clinical policies, and risk to Trust reputation.

Risk Score	Risk Score	Likelihood	Consequence
Current	**12**	3	4
Target	**8**	2	4

NB: Risk score has recently been reduced from 16 to 12 in view of the progress made bringing policies within review date, the prioritisation/policy work plan agreed for 2027/28, and the current mitigations in place.

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	n/a

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
n/a	n/a

SITUATION

1. The purpose of this report is to provide the Audit, Risk and Assurance Committee (ARAC) with a six-monthly update on the Trust's policy governance arrangements, progress against the policy work programme, and the status of actions arising from the 2025 Audit Wales Structured Assessment.

2. In particular, the report updates Members on Recommendation 2, which required the Trust to review and strengthen its Policy on Policies and develop a more efficient and proportionate approach to managing written control documents, including the appropriate use of procedures, guidance and other supporting documents where these better reflect operational requirements.

BACKGROUND

5. The Audit Wales 2025 Structured Assessment recommended that *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* The Trust accepted the recommendation and committed to developing a Policy Transformation Programme, initially scheduled to be scoped during Quarter 4 of 2025/26, with committee oversight from Quarter 1 of 2026/27. The original implementation milestone was 31 July 2026.

6. In March 2026 a draft project brief was prepared to define the scope, principles and intended outcomes of a future written control document transformation programme in line with the agreed management action. This work has confirmed that implementation would require a significant programme of organisational change involving the review, rationalisation and reclassification of a large number of written control documents (including SOPs, guidelines, procedures etc as well as policies) across the Trust. Whilst the strategic rationale for the programme remains valid, current Corporate Governance Directorate capacity does not allow this work to be progressed beyond initial scoping at the present time.

ASSESSMENT

7. In assessing the position that the transformation programme must be deferred, the level of risk was considered. The programme is not currently included within the Trust's Integrated Medium Term Plan (IMTP), and the overall level of risk exposure remains relatively low with the following mitigations:

    - Trust policies remain extant and do not automatically expire and continue to provide an appropriate governance framework until formally reviewed or superseded.
    - A range of standard operating procedures, guidance documents and clinical guidelines (including national JRCALC guidance) remain in place to support operational and clinical decision-making.
    - Most workforce related policies are developed and approved on an NHS All Wales basis for the Trust to adopt.
    - Our 2025 internal audit programme noted that there were more operational implementation issues in policies, rather than design issues, suggesting that policies are in place but are not always being implemented correctly.

8. Further assurance is provided through existing governance and assurance mechanisms. The Trust's annual internal and external audit programmes routinely identify areas where policy design, implementation or compliance require strengthening, enabling management action to be taken where risks emerge. In addition, a significant proportion of workforce-related policies are developed and approved on an NHS Wales basis for adoption by the Trust, reducing the requirement for extensive Trust-led policy development in these areas. Strategic and operational guidance arrangements also continue to support delivery of key organisational objectives and provide alternative control mechanisms where the development of a formal policy is not proportionate.

9. Taking account of the capacity constraints and the level of risk exposure, the management action for the 2025 Structured Assessment recommendation will be amended. The amendment will focus on policies in particular in an attempt to streamline the process and increase the currency of policies. The revised action is set out below and will return to this committee in Q4 for endorsement of the revised approval framework:

Review existing policy documentation and develop a revised template, approval process and supporting policy and process that streamlines workflow, clarifies roles and responsibilities, and establishes a consistent approach across the Trust.

2026/27 Policy Work Programme

10. At the beginning of the 2026/27 financial year, a policy prioritisation exercise was undertaken involving the Trust's Policy Group and directorates. All outstanding Trust-owned policies (not yet within review date compliance), as well as any new policies proposed for development, were considered. Out of the 49 policies carried over from 2025/26 to 2026/27 that were within scope:

    - 21 Policies were already under review / on approval route
    - 13 Policies identified as business-critical (to be prioritised during 2026/27)
    - 3 Policies for decommission or reclassification
    - 8 Policies non-urgent / low risk (deferred to 2027/28)
    - 4 Policies either on hold (awaiting national guidance) or no longer required

11. Reasonable progress has been made against the 2026/27 Policy Work Programme, with 16 out of 31 (43%) of the policies scheduled either having been approved or at consultation stage. The remaining policies are in train and have dates for submission to the Trust's Policy Group before 31 March 2026, which have been advised by directorates and agreed by the Executive Leadership Team (ELT).

12. The 2026/27 policy prioritisation programme was approved the ELT in July 2026.

Current Compliance

13. As of 19 August 2026, there were 79 existing Trust-owned policies, of which 41 had been reviewed and approved and were within review date compliance, and a further 9 policies were at the consultation stage with approval imminent. This equates to 50 out of 79 policies (63%) within review date compliance – an improvement of +13% compared to the 50% compliance reported in August 2025.

Based on current scheduling, a further five reviewed policies are due to be presented to the Trust's Policy Group in September 2026.

Reporting and Monitoring

14. Monthly updates continue to be provided to the Executive Leadership Team through an Alert/Advise/Assure (AAA) highlight report following each Policy Group meeting. This ensures ongoing executive scrutiny and early identification of risk or slippage.

Overall Assurance

15. The Trust has achieved measurable improvement in policy governance since September 2023 when the post Covid-19 pandemic position was 14% (now 63%). There is strengthened oversight of high-priority policies and established clearer governance controls around sign off processes. While year-end compliance will be below the original ambition due to approved deferrals and operational pressures, delivery remains on an improving trajectory with credible plans in place to sustain progress until the end March 2027.

RECOMMENDATION(S)

16. The recommendations are set out on the front cover.

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

Agenda Item No.	10

REPORT TITLE

Assurance to the Audit Risk and Assurance Committee on the speaking up safely framework (from Chair of People and Culture Committee)

MEETING

Name of Meeting	Audit Risk and Assurance Committee
Date of Meeting	3 September 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Ceri Jackson, Vice Chair of Trust Board Chair of People and Culture Committee
Author(s) of report	Sarah Harland, Corporate Governance Officer

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 National Audit Office Effectiveness Tool requires that the Audit Risk and Assurance Committee (ARAC) ensures the organisation operates appropriate and effective whistleblowing practices, and this is regularly considered by ARAC. The People and Culture Committee (PCC) has the following mandate it its terms of reference which were approved by the Trust Board on 29 January 2026: "3.9 *(a)-(c) Receive assurance that arrangements are in place to allow staff to raise concerns in confidence, ensure that those processes allow any such concerns to be investigated proportionately and independently, and receive assurance that the learning from such concerns is considered and applied*".

2. As Chair of the PCC and Non-Executive Director Champion for Raising Concerns, I provide the following required assurance to the ARAC of the robustness of the arrangements regarding the Speaking Up Safely arrangements in the Welsh Ambulance Services University NHS Trust (WAST).

3. The Speaking Up Safely service continued to mature throughout 2025/26 following the establishment of a dedicated team and a strategic focus on awareness, accessibility, organisational learning and improvement. During the reporting year, the service received 106 new concerns, demonstrating sustained staff engagement and growing confidence in speaking up mechanisms. Annual activity patterns remained consistent, with increased reporting during Speaking Up Safely Month and further growth towards the end of the year.

4. Significant progress has been achieved in raising awareness and improving access to support. Key developments included enhanced communications, newsletters, educational resources and targeted support for students and colleagues who may previously have faced barriers to speaking up. Partnership working with operational teams and educational establishments has improved understanding of available routes for support and contributed to an increase in concerns being raised appropriately.

5. The service has continued to influence practice beyond the Trust through participation in national ambulance sector networks. WAST played a leading role in developing national work relating to detriment mitigation and was recognised as the most improved ambulance service for Staff Survey Speaking Up results within the 2024/25 reporting cycle.

6. Analysis of concerns shows that most concerns originated from the Operations Directorate, reflecting the size of the workforce within that area. Concerns relating to inappropriate attitudes, behaviours, bullying and harassment and sexual safety remain the most common reasons for speaking up, accounting for approximately 65% of all cases. Collaboratively working with this

directorate has seen greater awareness and support from our leaders. Data also demonstrates that concerns are frequently raised regarding individuals in more senior positions, reinforcing the importance of maintaining trusted and independent reporting mechanisms.

7. Looking forward, the service will focus on reducing detriment, strengthening organisational learning, enhancing data capability, developing educational resources and further embedding the Just and Learning Culture Forum. Continued implementation of the Detriment Mitigation Action Plan and development of an e-learning package will support cultural improvement and staff confidence in speaking up through all channels across the Trust.

8. At the meeting of the PCC 11 August 2026, members welcomed the progress made in embedding a culture where staff feel able to speak and discussed the importance of ensuring concerns result in visible and meaningful outcomes. Discussion focused on feedback indicating that some individuals remained unconvinced that concerns would lead to change. Members emphasised the importance of effective communication, organisational learning and strengthening management capability to address concerns through traditional reporting routes wherever possible. Lizzie O'Shea (Speaking Up Safely Guardian) and Angela Lewis (Director of Culture Change) highlighted the need for managers to feel confident managing complex and sensitive issues, whilst continuing to address the risk of detriment experienced by individuals who raise concerns.

9. As Committee Chair, I welcomed the continued progress made in the Speaking Up Safely agenda and highlighted the importance of maintaining momentum, strengthening organisational culture and ensuring that staff see positive outcomes from raising concerns. The Committee received assurance from the report and supported the continued development of the Speaking Up Safely programme.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Audit Risk and Assurance Committee is asked to receive assurance on the arrangements for Speaking Up Safely at WAST, and to note that the People and Culture Committee will continue its oversight of this area, reporting annually to ARAC.

ADDITIONAL PAPER(S)

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

n/a

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

Agenda Item No.	11

REPORT TITLE

Assurance to Audit Risk and Assurance Committee on Near Miss and Low Harm Intelligence Reporting (from Chair of Quality Patient Experience and Safety Committee)

MEETING

Name of Meeting	Audit Risk and Assurance Committee
Date of Meeting	3 September 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Bethan Evans, Chair of Quality Patient Experience and Safety Committee
Author(s) of report	Sarah Harland, Corporate Governance Officer

PURPOSE OF REPORT

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

REPORT SUMMARY

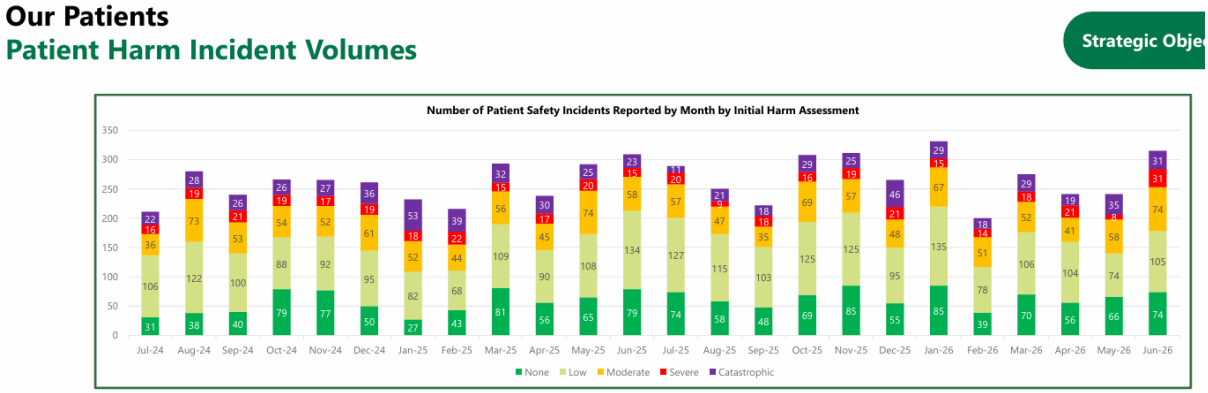
[See writing and presentation guidance here to inform this section]

1. The National Audit Office Effectiveness Tool requires that the Audit, Risk and Assurance Committee (ARAC) ensures the organisation operates appropriate and effective practices regarding the recording and management of near miss and low harm incidents, and this is regularly considered by ARAC.

2. The purpose of this report is to provide assurance to the ARAC that the Quality, Patient Experience and Safety Committee (QuEST) receives regular update regarding the arrangements in the Trust relating to none and low harm patient safety incidents.

3. QuEST receives a 'concerns, patient safety and legal services' report at each quarterly meeting that provides details of the number of patient safety incidents reported by month by initial harm assessment. That report is also included in the MIQPR and draws out out 'none' and 'low' harm reporting as can be seen below from the August QuEST meeting pack:

Our Patients
Patient Harm Incident Volumes



4. QuEST have been monitoring compliance measures including Duty of Candour, Learning from Events reporting and reductions in overdue Nationally Reportable Incidents and while there have been improvements there are ongoing pressures. These include the high volume of cases and changes in regulations, and these are being addressed through the Concerns Management Improvement Programme, although improvement has not yet been fully realised. So whilst no and low harm incidents are reported to QuEST there is by necessity focus on improvement of the overall picture.

5. A further piece of work will be undertaken to define other areas where near miss reporting may be relevant, particularly in respect of incidents raised by staff and health and safety incidents. These will be incorporated in future reports where relevant.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section
The Audit Risk and Assurance Committee is asked to note the annual report.

ADDITIONAL PAPER(S)

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

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

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

Agenda Item No.	12

REPORT TITLE

Losses and Special Payments (Payments for the period 1 April - 31 July 2026)

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	3 September 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 four months from 1 April to 31 July 2026 (**Annex 1**).

2. Total net Losses and Special Payments made were as follows:
   - Period 1 April to 31 July 2026 - £0.409m

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 four months to 31 July 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 & 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 four months from 1 April to 31 July 2026 **Annex 1**.

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1 April to 31 July 2026 amounted to £0.409 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 four months to 31 July 2026 payments exceeded reimbursements made by £0.409m.

5. During June and July 2026, damages payments totalled £0.102m. The largest proportion of these payments related to two individual cases, with settlements of £0.053m and £0.030m. These claims related to clinical negligence and personal injury, respectively.

RECOMMENDATION(S)

6. The recommendation(s) are set out in the front cover.

NEXT STEPS

7. 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 four months to 31st July 2026

	£
April 2026	£85,206.41
May 2026	£93,637.62
June 2026	£124,381.60
July 2026	£106,221.20
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
	£409,446.83

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	270.00	21,022.35									90,898.54
Counsel fees	1,847.50	3,563.50	17,268.33	14,168.50									36,847.83
CRU	2,338.00	0.00	743.00	5,699.00									8,780.00
Damages	9,578.24	2,500.00	56,388.80	45,140.00									113,607.04
Defence Costs	26,244.63	5,731.52	41,586.10	1,269.82									74,832.07
Expert Witness	11,217.71	0.00	0.00	500.00									11,717.71
Vehicle Repairs	18,602.94	24,490.80	8,395.77	18,421.53									69,911.04
WRP Refund	2,475.00	0.00	-400.00	0.00									2,075.00
Property Repairs	0.00	648.00	129.60	0.00									777.60
Court Refund													0.00
Total	**£85,206.41**	**£93,637.62**	**£124,381.60**	**£106,221.20**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£409,446.83**

22RT4PI0006

Welsh Ambulance Services University NHS Trust	Key	
Losses and Special Payments	MN	Medical Negligence
	PI	Personal Injury
Summary of payments for the four months to 31st July 2026	DP	Damage To Property
	£	
DP cases < £1,000	7,202.49	23 Cases
Redress cases < £1000		
PI cases < £1000	3,759.00	5 Cases
26RT4MN0027	53,000.00	
25RT4MN0019	30,500.00	
23RT4PI0016	30,000.00	
24RT4PI0033	24,500.00	
21RT4MN0009	14,400.00	
27RT4DP0009	12,136.39	
27RT4EG0019	11,500.00	
26RT4MN0024	10,000.00	
27RT4DP0002	9,654.68	
27RT4DP0031	9,070.22	
27RT4EG0004	9,000.00	
27RT4DP0019	8,317.72	
26RT4PI0016	5,828.40	
27RT4EG0005	5,750.00	
26RT4PI0001	5,504.35	
26RT4MN0017	5,500.00	
27RT4DP0018	5,140.55	
27RT4EG0016	5,000.00	
27RT4EG0020	5,000.00	
27RT4EG0021	5,000.00	
24RT4MN0007	4,738.33	
24RT4PI0058	4,703.80	
26RT4MN0010	4,560.00	
27RT4GN0001	4,500.00	
23RT4MN0014	4,418.50	
26RT4MN0013	4,168.00	
24RT4PI0070	4,073.50	
27RT4DP0001	3,998.63	
27RT4DP0008	3,877.42	
27RT4DP0016	3,822.16	
27RT4DP0030	3,549.02	
24RT4MN0012	3,530.00	
27RT4DP0011	3,332.10	
27RT4DP0021	3,300.00	
26RT4DP0114	3,100.26	
26RT4MN0015	3,045.00	
27RT4DP0006	3,042.64	
27RT4DP0032	2,984.21	
27RT4DP0024	2,864.54	
27RT4EG0002	2,730.00	
23RT4MN0002	2,695.00	
26RT4GN0010	2,640.00	
27RT4DP0020	2,614.30	
27RT4EG0018	2,500.00	
24RT4GN0022	2,475.00	
25RT4MN0016	2,475.00	
27RT4DP0007	2,439.92	
24RT4MN0005	2,375.00	
27RT4EG0012	2,250.00	
27RT4DP0010	2,248.45	
20RT4PI0037	2,225.00	
25RT4MN0028	2,100.00	
27RT4DP0029	2,086.60	
27RT4EG0009	2,000.00	
24RT4PI0031	1,911.00	
27RT4DP0015	1,838.58	
27RT4DP0004	1,649.35	
24RT4PI0041	1,606.00	
26RT4EG0035	1,500.00	
27RT4EG0003	1,500.00	
27RT4EG0013	1,500.00	
25RT4MN0027	1,375.00	
27RT4DP0023	1,354.36	
26RT4DP0117	1,308.86	
27RT4EG0008	1,295.00	
23RT4MN0021	1,260.00	
26RT4EG0024	1,250.00	
26RT4DP0055	1,200.00	
26RT4EG0043	1,000.00	
26RT4EG0048	1,000.00	
26RT4GN0014	1,000.00	
27RT4EG0011	1,000.00	
27RT4EG0015	1,000.00	
25RT4MN0020	472.50	
25RT4MN0017	400.00	
24RT4MN0011	200.00	
26RT4GN0009	- 400.00	WRP REFUND
Total	**409,446.83**	

Welsh Ambulance Services University NHS Trust
Jun-26

Case Reference	Details	Amount (£)
20RT4PI0037	COUNSEL FEES	1,500.00
24RT4PI0041	COUNSEL FEES	800.00
23RT4MN0002	COUNSEL FEES	2,695.00
23RT4MN0014	COUNSEL FEES	1,050.00
23RT4MN0014	COUNSEL FEES	900.00
24RT4MN0007	COUNSEL FEES	133.33
24RT4MN0011	COUNSEL FEES	200.00
24RT4MN0012	COUNSEL FEES	2,730.00
25RT4MN0017	COUNSEL FEES	400.00
26RT4MN0010	COUNSEL FEES	3,360.00
26RT4MN0017	COUNSEL FEES	3,500.00
27RT4EG0011	PROFESSIONAL FEES	1,000.00
27RT4EG0012	PROFESSIONAL FEES	2,250.00
27RT4EG0013	PROFESSIONAL FEES	1,500.00
27RT4EG0014	TRANSCRIPTION COSTS	86.10
27RT4EG0015	PROFESSIONAL FEES	1,000.00
27RT4DP0010	DAMAGE TO VEHICLE	39.96
27RT4DP0023	DAMAGE TO VEHICLE	1,146.86
27RT4EG0016	PROFESSIONAL FEES	5,000.00
27RT4EG0005	PROFESSIONAL FEES	2,250.00
27RT4DP0017	DAMAGE TO PROPERTY	129.60
27RT4DP0024	DAMAGE TO VEHICLE	36.00
27RT4DP0019	DAMAGE TO VEHICLE	894.00
27RT4DP0018	DAMAGE TO VEHICLE	791.53
27RT4DP0018	DAMAGE TO VEHICLE	1,000.00
27RT4EG0005	PROFESSIONAL FEES	2,500.00
27RT4EG0018	PROFESSIONAL FEES	2,500.00
27RT4DP0025	DAMAGE TO VEHICLE	550.00
26RT4EG0043	PROFESSIONAL FEES	1,000.00
27RT4DP0026	DAMAGE TO VEHICLE	750.00
27RT4EG0019	PROFESSIONAL FEES	11,500.00
27RT4DP0024	DAMAGE TO VEHICLE	2,828.54
27RT4EG0020	PROFESSIONAL FEES	5,000.00
27RT4EG0005	PROFESSIONAL FEES	1,000.00
21RT4PI0021	CRU	743.00
26RT4PI0016	GENERAL DAMAGES SETTLEMENT	643.40
26RT4PI0016	GENERAL DAMAGES SETTLEMENT	2,145.40
26RT4PI0021	GENERAL DAMAGES SETTLEMENT	600.00
26RT4PI0021	CLAIMANTS SOLICITORS FEES	270.00
26RT4MN0027	GENERAL DAMAGES SETTLEMENT	53,000.00
27RT4DP0027	DAMAGE TO VEHICLE	358.88
27RT4EG0021	PROFESSIONAL FEES	5,000.00
26RT4GN0009	WRP REFUND	- 400.00
Totals		**124,381.60**

Welsh Ambulance Services University NHS Trust
Jul-26

Case Reference	Details	Amount (£)
24RT4PI0070	COUNSEL FEES	1,573.50
23RT4MN0021	COUNSEL FEES	1,260.00
24RT4MN0005	COUNSEL FEES	625.00
24RT4MN0007	COUNSEL FEES	2,785.00
24RT4MN0012	COUNSEL FEES	800.00
25RT4MN0016	COUNSEL FEES	1,175.00
25RT4MN0016	COUNSEL FEES	450.00
25RT4MN0016	COUNSEL FEES	700.00
25RT4MN0028	EXPERT WITNESS	500.00
25RT4MN0028	COUNSEL FEES	1,600.00
26RT4MN0010	COUNSEL FEES	1,200.00
26RT4MN0017	COUNSEL FEES	2,000.00
27RT4EG0022	TRANSCRIPTION SERVICES	79.12
27RT4EG0023	TRANSCRIPTION SERVICES	32.85
27RT4EG0024	TRANSCRIPTION SERVICES	157.85
26RT4EG0048	PROFESSIONAL FEES	1,000.00
27RT4DP0029	DAMAGE TO VEHICLE	456.03
27RT4DP0029	DAMAGE TO VEHICLE	1,630.57
27RT4DP0030	DAMAGE TO VEHICLE	49.02
27RT4DP0031	DAMAGE TO VEHICLE	9,070.22
27RT4DP0032	DAMAGE TO VEHICLE	2,984.21
27RT4DP0033	DAMAGE TO VEHICLE	429.98
27RT4DP0030	DAMAGE TO VEHICLE	3,500.00
27RT4DP0023	DAMAGE TO VEHICLE	207.50
27RT4DP0034	DAMAGE TO VEHICLE	94.00
20RT4PI0037	CRU	725.00
23RT4PI0016	GENERAL DAMAGES SETTLEMENT	30,000.00
24RT4PI0041	CRU	806.00
24RT4PI0070	GENERAL DAMAGES SETTLEMENT	2,500.00
26RT4PI0001	CLAIMANTS SOLICITORS FEES	5,504.35
26RT4PI0016	CLAIMANTS SOLICITORS FEES	1,118.00
21RT4MN0009	CLAIMANTS SOLICITORS COSTS	14,400.00
26RT4MN0013	CRU	4,168.00
26RT4MN0024	GENERAL DAMAGES SETTLEMENT	10,000.00
26RT4MN0024	CRU	3,885.00
26RT4GN0010	PROFESSIONAL SERVICES	2,640.00
26RT4MN0024	CRU REFUND	- 3,885.00
Totals		**106,221.20**

Agenda Item No.	13

REPORT TITLE

Non-compliance with standing orders: publication of late papers

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	3 September 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. This report to the Audit, Risk and Assurance Committee (ARAC) is in response to the 2025 Audit Wales Structured Assessment setting out the non-compliance against standing orders in regard to publication of papers. The recommendation requires that the Trust report any board or committee papers submitted after the five-day publication deadline as a breach.

2. The Trust's standing orders, provision 7.4.8 state that board papers will be made available to the public at least five clear days before each meeting of the board. The Trust extends this provision to the committees of the board, in addition to the trust board and meetings of the Corporate Trustee.

3. In line with the agreed management action from the Structured Assessment, the Corporate Governance team continues to maintain a log of papers published after midday on the *seventh day before* the relevant meeting, in line with the Trust's board and committee secretariat standard operating procedure.

4. Between 21 February 2026 – 24 August 2026, 11 papers have been recorded as late, as detailed in appendix one. This figure includes one late paper received for the private meeting of the Finance and Performance Committee (FPC), the detail for which has been reported to the private ARAC. This reflects the continued reporting arrangement established to provide ARAC with oversight of late publication and support timely submission of papers.

5. Where late papers are received it is the Chair of the Trust Board or the respective committee who provides approval to its late upload/publication. Papers listed in appendix one were known to be expected late prior to the seven-day publication deadline, and this was communicated to the respective chairs.

6. To date, the Trust Board has received reporting against progress on the Integrated Medium-Term Plan (IMTP) similar to that which the FPC receives, and as a result there are sometimes delays with the finalisation of the paper for presentation to the Trust Board due to the placement of the FPC meeting being the week before the Trust Board. The revised IMTP reporting to committees and the board from Q2 2026/27 should mitigate this issue.

7. Additionally, work is underway to agree a cut-off date for the finalisation of the MIQPR. Whilst this will mean that there is a lag in the data at the point at which it is received by the board or a committee, it will mitigate the issue of late MIQPR papers for meetings. Where possible, either a verbal or written update on the current position will be provided to supplement the paper.

8. It is noted that it is often the case that the FPC AAAs are published for the Trust Board after the initial board publication due to the proximity of the FPC meeting with the publication date for the board (being two calendar days later than the FPC meeting). All endeavours are made to prepare and approve the AAA for FPC with haste; however, they are sometimes published late due to the timeframes described here.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The committee is requested to:

1. Receive and note the report of non-compliance with standing orders in regard to publication of late papers from 21 February 2026 – 24 August 2026.

ADDITIONAL PAPER(S)

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

n/a

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 & 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

Appendix one:

Meeting	Meeting date	Item	Paper title	Days late
Trust Board, public	26 March 2026	6	Chief Executive's Report	2
Trust Board, public	26 March 2026	9	Accessing Avoidable Harm	3
Trust Board, public	26 March 2026	10	Monthly Integrated Quality and Performance Report (MIQPR)	3
Trust Board, public	26 March 2026	11.1	Integrated Medium Term Plan (IMTP) 2026-2029	3
Trust Board, public	26 March 2026	13	Integrated Medium Term Plan (IMTP) 2025-26 Progress Report	1
Finance and Performance Committee (FPC) public	19 May 2026	11	Monthly Integrated Quality and Performance Report (MIQPR)	1
Trust Board, public	28 May 2026	9	Monthly Integrated Quality and Performance Report (MIQPR)	1
FPC public	21 July 2026	8	Integrated Medium Term Plan (IMTP) Progress Report	1
FPC public	21 July 2026	9	Monthly Integrated Quality Performance Report (MIQPR) May/June 2026	2
Trust Board, public	30 July 2026	12	Monthly Integrated Quality and Performance Report (MIQPR)	1

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

Agenda Item No. 14

REPORT TITLE

Scheme of Reservation and Delegation of Powers (SoRD) Review

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	3 September 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance
Author(s) of report	Trish Mills, Director of Corporate Governance

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 Scheme of Reservation and Delegation of Powers (SoRD) is a key governance document that sits alongside the Trust's Standing Orders and Standing Financial Instructions, setting out those matters reserved to the board and those delegated to officers of the Trust.

2. The SoRD has been reviewed following changes to executive leadership team (ELT) portfolios and role nomenclature, including the introduction of the Chief Clinical Officer, and the change of titles from Director of People to Chief People Officer, and Executive Director of Operations to Chief Operating Officer. Several consequential amendments are required to ensure the document accurately reflects current organisational structures and accountabilities and these are attached and marked up at **Annex 1**.

3. A broader review of the SoRD is required, however additional work is needed before substantive changes are brought forward. This includes review of areas relating to the ex gratia payments under the Welsh Government Manual for Accounts to ensure alignment, policy-related delegations, workforce and establishment controls, and local directorate delegation arrangements. For this reason, only the nomenclature and role changes are sought.

4. The ELT considered whether the Chief Executive's delegated financial limit should be increased following discussion at the May 2026 Finance and Performance Committee. Having reviewed benchmarking information and considered the Trust's forthcoming procurement programme, ELT concluded that the current delegation remains proportionate and that no increase should be made at this stage. Members noted that the Trust would be out of step with other NHS Wales organisations were the limit to be increased and were satisfied that existing board and committee oversight arrangements remain manageable and appropriate.

5. As part of the interim amendments, retrospective endorsement is sought for Angela Lewis, Director of Culture Change, to exercise, from 28 June 2026, the delegations assigned to the Director of People following Carl Kneeshaw's departure. For the avoidance of doubt, the Director of People role is redesignated as Chief People Officer within the revised Scheme of Reservation and Delegation of Powers, and the associated delegations will transfer accordingly

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The committee is asked to:

1. Endorse for the board's approval the interim amendments to the Scheme of Reservation and Delegation of Powers at Annex 1 to reflect current executive role titles, portfolio responsibilities and interim executive arrangements;

2. Endorse retrospective application of the delegations previously assigned to the Director of People to Angela Lewis, Director of Cultural Change, from 28 June 2026; and

3. Note the intention to undertake a broader review of the SoRD and receive a further revised version following completion of that work.

ADDITIONAL PAPER(S)

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

Annex 1 Scheme of Reservation and Delegation of Powers Schedule 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 risks 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
17 August 2026	Executive Leadership Team

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

Schedule 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

(i) A Committee, e.g., Quality and Safety Committee;

(ii) A sub-Committee e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board; and

(iii) Officers of the Trust (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the Trust. The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the Trust's Standing Orders.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and***

the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles)
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Board Secretary

The Board Secretary will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of Trust functions within the organisation and to others, as appropriate; and

- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit, Risk and Assurance Committee

The Audit, Risk and Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Trust's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of control and other established procedures within the Trust.

SCHEDULE OF MATTERS RESERVED TO THE BOARD[1]

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
1	Board	General	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs.
2	Board	General	The Board must determine any matter that will be reserved to the whole Board.
3	Board	General	Approve the Trust's Governance Framework
4	Board	Operating Arrangements	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the Trust; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	Board	Operating Arrangements	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements.

[1] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
6	Audit, Risk and Assurance Committee	Operating Arrangements	Formal consideration of report of Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.
7	Board	Operating Arrangements	Receive report any proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	Board	Operating Arrangements	Authorise use of the Trust's official seal.
9	Board	Operating Arrangements	Approve the Trust's Values and Standards of Behaviour framework.
10	Chair on behalf of Board/Joint Committee, Vice-Chair on behalf of Joint Committee Board if Chair is declaring interest	Organisation Structure and Staffing	Require, receive, and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit, Risk and Assurance Committee or Board Secretary
11	Board	Strategy Planning	Determine the Trust's strategic aims, objectives, and priorities
12	Board	Strategy Planning	Approve the Trust's key strategies and programmes related to: ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans) ▪

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
13	Board	Strategy Planning	Approve the Trust's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
14	Board	Strategy Planning	Approve the Trust's budget and financial framework (including overall distribution and unbudgeted expenditure)
15	Board	Operating Arrangements	Approve the Trust's framework and strategy for performance management.
16	Board	Strategy and Planning	Approve the Trust's framework and strategy for risk management and assurance.
17	Board	Operating Arrangements	Ratify policies for dealing with raising concerns, complaints, and incidents in accordance with ~~the Putting Things Right~~Listening to People Regulations and health and safety requirements.
18	Board	Operating Arrangements	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Trust, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE).
19	Board	Strategy and Planning	Approve the Trust's patient, public, staff, partnership and stakeholder engagement and co-production strategies.
20	Board	Operating Arrangements	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the Trust's aims, objectives and priorities.
21	Remuneration Committee. (For Chief Executive,	Organisation Structure and Staffing	Appointment of the Chief Executive and Executive Directors (officer members of the Board)

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
	Committee to consist of Chair and non-Officer Members. For all others officer members as above and to include Chief Executive)		
22	Remuneration Committee	Organisation Structure and Staffing	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial instructions e.g. the Board Secretary.
23	Remuneration Committee	Organisation Structure and Staffing	Termination of appointment and suspension of officer members in accordance with the provisions of Regulations
24	Remuneration Committee	Organisation Structure and Staffing	Consider appraisal of officer members of the Board
25	Remuneration Committee	Organisation Structure and Staffing	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
26	Board	Organisation Structure and Staffing	Approve, [arrange the] review, and revise the Trust's top level organisation structure and corporate policies
27	Board	Organisation Structure and Staffing	Appoint, [arrange the] review, revise and dismiss Trust Committees directly accountable to the Board

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
28	Board	Organisation Structure and Staffing	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee or Group set up by the Board
29	Board	Organisation Structure and Staffing	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
30	Board	Organisation Structure and Staffing	Approve the standing orders and terms of reference and reporting arrangements of all Committees and groups established by the Board
31	Audit, Risk and Assurance Committee	Operating Arrangements	Approve arrangements relating to the discharge of the Trust's responsibility as a bailee for patients' property
32	Board Except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	Operating Arrangements	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
33	Board Except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	Operating Arrangements	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
34	Board	Operating Arrangements	Approve proposals for action on litigation on behalf of the Trust
35	Board	Organisation Structure and Staffing	Approve the arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.
36	Board	Strategy and Planning	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions[2]
37	Board	Performance and Assurance	Approve the Trust's audit and assurance arrangements
38	Board	Performance and Assurance	Receive reports from the Trust's Executive on progress and performance in the delivery of the Trust's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate.
39	Board	Performance and Assurance	Receive reports from the Trusts Committees, groups and other internal sources on the Trust's performance and approve action required, including improvement plans, as appropriate
40	Board	Performance and Assurance	Receive reports on the Trust's performance produced by external regulators and inspectors (including, e.g., Audit Wales etc.) that raise significant issue or concerns impacting on the Trust's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Trust Committees (as appropriate)
41	Board	Performance and Assurance	Receive the annual opinion of the Trust's Chief Internal Auditor and approve action required, including improvement plans
42	Board	Performance and Assurance	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans

2 In this respect individual contracts refers to individual awards

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
43	Board	Performance and Assurance	Receive assurance regarding the Trust's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
44	Board	Reporting	Approve the Trust's Reporting Arrangements, including reports on activity and performance to citizens, partners and stakeholders and nationally to the Welsh Government where required.
45	Board	Reporting	Receive, approve and ensure the publication of Trust reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
1.	Chair		In accordance with statutory and Welsh Government requirements
2.	Vice Chair		In accordance with statutory and Welsh Government requirements
3.	Champion/ Nominated Lead		In accordance with statutory and Welsh Government requirements

DELEGATION OF POWERS TO COMMITTEES AND OTHERS[3]

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- The composition, terms of reference and reporting requirements in respect of any such Committees; and
- The governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to the following Committees and others:

- Audit, Risk and Assurance Committee
- Quality Patient Experience and Safety Committee
- Remuneration Committee
- Finance and Performance Committee
- People and Culture Committee
- Charity Committee
- Academic Partnerships Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the Trust's Scheme of Delegation to Committees. The Committee terms of reference appear in Schedule 3 to these Standing Orders.

[3] As defined in Standing Orders.

In the event the Chief Executive Officer is absent ~~they will appoint~~the ~~a~~ Deputy Chief Executive Officer to take on full responsibility of the Chief Executive Officer. ~~If the Deputy Chief Executive is the Director of Finance and Corporate Resources, then the Director of Finance and Corporate Resources responsibilities is delegated to the relevant Assistant Director of Finance.~~

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, DIRECTORS AND OFFICERS

The Trust SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and Corporate Resources and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders.

These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the Trust's Scheme of Delegation to Officers.

Table A – Delegated Matters

Note for Table A, where a delegation is made to more than one post holder:

- '/' signifies that either post holder may act individually, or they may act jointly.
- 'and' signifies they must act jointly

Delegated Matter	Responsible Officer/Committee	Delegated To
1. Audit arrangements		
1.1. Ensure that there is an adequate provision of internal and external audit services	Audit, Risk and Assurance Committee	Director of Corporate Governance/Board Secretary
1.2. Implement recommendations	Chief Executive	Relevant Director
1.3. Ensure the financial accounts of the Trust are audited annually	Chief Executive	Executive Director of Finance and Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
2. Authorisation of new drugs	Chief Executive	~~Executive Director of Paramedicine~~Chief Clinical Officer and Associate Medical Director
3. Bank/OPG Accounts/Cash (Excluding Charitable Funds (Funds Held on Trust Accounts)) Refer to SFIs for banking arrangements	Chief Executive	Executive Director of Finance & Corporate Resources
4. Capital investment (Refer to SFIs)		
4.1. Programme		
(a) Preparation of Capital Investment for submission to Board	Chief Executive	Executive Director of Finance & Corporate Resources and Director of Strategy, Planning & Performance
(b) Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Chief Executive	Executive Director of Finance & Corporate Resources
(c) Variation to capital programme (up to delegated limits)	Chief Executive	Executive Director of Finance & Corporate Resources and Director of Strategy, Planning & Performance
4.2. Leases – granting and termination of leases subject to the limits set out in Table B	Chief Executive	Executive Director of Finance & Corporate Resources
5. Clinical		
5.1. Clinical governance arrangements	Chief Executive	~~Executive Director of Quality & Nursing and Executive Director of Paramedicine~~Chief Clinical Officer
5.2. Clinical leadership	Chief Executive	~~Executive Director of Quality & Nursing and Executive Director of Paramedicine~~Chief Clinical Officer
5.3. Programmes of clinical education	Chief Executive	~~Director of People~~Chief People Officer ~~with Executive Director of Quality & Nursing~~ and ~~Executive Director of Paramedicine~~Chief Clinical Officer

Delegated Matter	Responsible Officer/Committee	Delegated To
5.4. Clinical staffing rotas	Chief Executive	~~Executive Director of Operations~~Chief Operating Officer
5.5. Clinical trials and research projects (authorisation of) In accordance with JRCALC guidelines	Chief Executive	~~Executive Director of Paramedicine~~Chief Clinical Officer unless specified as Associate Medical Director
5.6. Responsible officer for medical revalidation	Chief Executive	Associate Medical Director
5.7. Clinical Audit To ensure there is a programme in place	Chief Executive	~~Executive Director of Paramedicine~~Chief Clinical Officer
6. Clinical Practice and Registration		
6.1. Compliance with statutory and regulatory arrangements relating to professional practice and/or breaches of clinical standards		
(a) Nursing	Chief Executive	~~Executive Director of Quality and Nursing~~Chief Clinical Officer
(b) Medical	Chief Executive	Associate Medical Director
(c) Paramedicine and affiliated roles	Chief Executive	~~Executive Director of Paramedicine~~Chief Clinical Officer
(d) Community First Responders	Chief Executive	~~Executive Director of Paramedicine~~Chief Clinical Officer
7. Complaints/concerns (patients and relatives) – ~~Putting Things Right/the NHS (Concerns, Complaints and Redress Arrangements (Wales)) Regs 2011~~including Listening to People Regulations	Chief Executive	~~Executive Director of Quality & Nursing~~Chief Clinical Officer
8. Confidential information		
8.1. Monitoring of the Trust's compliance with the Caldicott report on protecting patient confidentiality in the NHS	Chief Executive	~~Executive Director of Quality and Nursing~~Chief Clinical Officer
8.2. Freedom of Information Act compliance code	Chief Executive	Director of Corporate Governance/Board Secretary
9. Data Protection Act and General Data Protection Regulations		

Delegated Matter	Responsible Officer/Committee	Delegated To
9.1. Monitoring of Trust's compliance	Chief Executive	Director of Digital Services
9.2. Senior Information Risk Owner (SIRO)	Chief Executive	Director of Digital Services
10. Declarations of interest		
10.1. Maintaining a register	Chief Executive	Director of Corporate Governance/Board Secretary
11. Disposal and condemnations		
11.1. Items obsolete, redundant, irreparable or cannot be repaired cost effectively	Chief Executive	Executive Director of Finance & Corporate Resources
11.2. Develop arrangements for the sale of assets	Chief Executive	Executive Director of Finance & Corporate Resources
11.3. Disposal of protected property (as defined in the terms of authorisation)	Chief Executive	Executive Director of Finance & Corporate Resources
12. Environmental Regulations		
12.1. Monitoring of compliance and ensuring compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Executive Director of Finance and Corporate Resources
13. External Borrowing		
13.1. Advise Trust Board of the requirements to repay / draw down Public Dividend Capital	Executive Director of Finance & Corporate Resources	(the relevant) Assistant Director of Finance
13.2. Approve a list of employees authorised to make short term borrowings on behalf of the Trust	Trust Board	Chief Executive and Executive Director of Finance & Corporate Resources
13.3. Application for draw down of Public Dividend Capital, overdrafts, and other forms of external borrowing	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
14. Financial Planning/Budgetary Responsibility		
14.1. Develop and submit to Trust Board a financial plan in accordance with priorities and objectives as set out in the IMTP	Chief Executive	Executive Director of Finance & Corporate Resources
14.2. Budgetary responsibility	Chief Executive	Executive Director of Finance & Corporate Resources
14.3. Prior to the start of the financial year, prepare and submit to Trust Board for approval balanced budgets that delivers the financial plan as contained within the IMTP	Chief Executive	Executive Director of Finance & Corporate Resources
14.4. Monitoring and report to Trust Board on performance against the financial plan	Chief Executive	Executive Director of Finance & Corporate Resources
14.5. Devise and maintain systems of budgetary control	Chief Executive	Executive Director of Finance & Corporate Resources
14.6. Monitor performance against budget	Chief Executive	Executive Director of Finance & Corporate Resources
14.7. Delegate budgets to budget holders	Chief Executive	Executive Director of Finance & Corporate Resources
14.8. Ensure adequate training is delivered to budget holders to facilitate their management of allocated budget	Chief Executive	Executive Director of Finance & Corporate Resources
14.9. Submit in accordance with the independent regulators' requirements for financial monitoring returns	Chief Executive	Executive Director of Finance & Corporate Resources
14.10. Identify and implement cost improvements and income generating activities in line with the business plan	Chief Executive	All budget holders
14.11. Preparation of		
(a) Annual accounts	Executive Director of Finance & Corporate Resources	(the relevant) Assistant Director of Finance

Delegated Matter	Responsible Officer/Committee	Delegated To
(b) Annual report	Chief Executive	Director of Corporate Governance/Board Secretary
14.12. Budget Responsibilities. Ensure that:		
(a) No overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board	Chief Executive and Executive Director of Finance & Corporate Resources	(the relevant) Assistant Director of Finance
(b) Approved budget is not used for any other than specified purpose subject to rules of virement	Chief Executive and Executive Director of Finance & Corporate Resources	(the relevant) Assistant Director of Finance
(c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and workforce establishment	Chief Executive and Executive Director of Finance & Corporate Resources	(the relevant) Assistant Director of Finance
14.13. Authorisation of Virement The Chief Executive, Executive Director of Finance & Corporate Resources and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.	Chief Executive	Executive Director of Finance & Corporate Resources
Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement		
15. Financial Procedures and Systems Development and maintenance of systems and procedures	Chief Executive	Executive Director of Finance & Corporate Resources
16. Fire Precautions	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
Ensure that the Fire Precautions and prevention policies and procedures are adequate, and that fire safety and integrity of the estate is intact.		
17. Fixed Assets		
17.1. Maintenance of asset register including asset identification and monitoring	Chief Executive	Executive Director of Finance & Corporate Resources
17.2. Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with NHS Infrastructure Investment Guidance	Chief Executive	Executive Director of Finance & Corporate Resources
17.3. Calculate and pay capital charges in accordance with the requirements of the Independent Regulator	Chief Executive	Executive Director of Finance & Corporate Resources
17.4. Responsibility for security of Trust's assets including notifying discrepancies to the Executive Director of Finance and Corporate Services, and reporting losses in accordance with Trust's procedures	Chief Executive	All Staff
18. Fraud (see also 26 and 36) Monitor and ensure compliance with Welsh Government Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Chief Executive	Executive Director of Finance & Corporate Resources
19. Funds Held on Trust Charitable Funds Charitable Funds held are managed and scrutinised appropriately	Charitable Funds Committee	Executive Director of Finance & Corporate Resources
20. Gifts and Hospitality		
20.1. Maintaining the gifts and hospitality register	Chief Executive	Director of Corporate Governance/Board Secretary
20.2. Process for declaring gifts and hospitality	Chief Executive	Director of Corporate Governance/Board Secretary
21. Health and Safety	Chief Executive	~~Executive Director of Quality & Nursing~~Chief Clinical Officer

Delegated Matter	Responsible Officer/Committee	Delegated To
Monitor and ensure statutory compliance with all legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations		
22. Infectious Diseases and Notifiable Outbreaks	Chief Executive	Executive Director of Quality & Nursing
23. Integrated Medium Term Plan (IMTP)		
23.1. Develop and present to Trust Board for approval an IMTP that sets out the Trust Strategies and objectives and meets Welsh Government requirement	Chief Executive	Executive Director of Strategy, Planning & Performance
24. IT Systems		
24.1. Ensuring integrity of system e.g. security, privacy, accuracy, completeness, and storage	Chief Executive	Director of Digital Services
24.2. Maintain & replacement of i) business critical systems ii) All other systems	Chief Executive	Director of Digital Services
24.3. Disaster recovery systems	Chief Executive	Director of Digital Services
24.4. Developing Business Critical Systems in accordance with the Trust's IM&T Strategy	Chief Executive	Director of Digital Services
24.5. Developing new systems to ensure they are developed in a controlled manner and thoroughly tested	Chief Executive	Director of Digital Services
24.6. Seeking third party assurances regarding Business Critical Systems operated externally	Chief Executive	Director of Digital Services
25. Losses, Write Offs and Compensation		

Delegated Matter	Responsible Officer/Committee	Delegated To
25.1. Prepare procedures for recording accounting and reporting to Audit, Risk and Assurance Committee for losses and special payments, including clinical negligence and personal injury claims	Chief Executive	Executive Director of Finance & Corporate Resources
25.2. Ex-gratia payments	Chief Executive	Executive Director of Finance & Corporate Resources and relevant Director
26. Patients' Property (in conjunction with financial advice) Ensuring patients and guardians are informed about patients' monies and property procedures	Chief Executive	~~Executive Director of Operations~~Chief Operating Officer
27. Patient Services Agreements Negotiation, agreement, and monitoring of external non-clinical patient transport contracts	Chief Executive	Executive Director of Finance & Corporate Resources/~~Executive Director of Operations~~Chief Operating Officer
28. Procuring Goods and Services		
28.1. Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Table B	Chief Executive	Executive Director of Finance & Corporate Resources
28.2. Obtain the best value for money when requisitioning goods/services	Chief Executive	Executive Director of Finance & Corporate Resources
28.3. Prompt payment to suppliers (pspp)	Chief Executive	Executive Director of Finance & Corporate Resources
28.4. Financial limits for ordering/requisitioning goods and services Refer to Table B for delegated limits	Chief Executive	Executive Director of Finance & Corporate Resources
29. Quotation, Tendering and Contract Procedures		
29.1. Services:		
(a) Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
(b) Nominate officers to oversee and manage the contract on behalf of the Trust	Chief Executive	Heads of Department
29.2. Competitive Tenders:		
(a) Authorisation to go to tender[4]	Chief Executive	Relevant Director
(b) Maintain a register to show each set of competitive tender invitations despatched	Chief Executive	Executive Director of Finance & Corporate Resources
(c) Receipt and custody of tenders prior to opening	Chief Executive	Executive Director of Finance & Corporate Resources
(d) Opening tenders	Chief Executive	Relevant Director
(e) Decide if late tenders should be considered	Chief Executive	Executive Director of Finance & Corporate Resources/Board Secretary
(f) Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote	Chief Executive	Executive Director of Finance & Corporate Resources
29.3. Quotations[4] Authorisation to seek quotations	Chief Executive	Relevant Director
29.4. Waiving the requirement to request[5]		
(a) Tenders – subject to Standing Financial Instructions (reporting to Audit, Risk and Assurance Committee)	Chief Executive	Executive Director of Finance & Corporate Resources

4 Individual awards of contract post tender and quotation are authorised in line with the delegations in Table B
5 See SFI 11.13.2 which provides the Executive Director of Finance and Corporate Resources approves applications for single tender waiver (STWs) up to £25,000, and the Chief Executive and Executive Director of Finance and Corporate Resources approve applications exceeding £25,000. It also provides that Procurement Services must be consulted prior to any such application being submitted for approval

Delegated Matter	Responsible Officer/Committee	Delegated To
(b) Quotes – subject to Standing Financial Instructions	Chief Executive	Executive Director of Finance & Corporate Resources
30. Reporting of Non-Urgent Incidents to the Police	Chief Executive	Relevant Director
31. Risk Management		
31.1. Ensuring the Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Director of Corporate Governance/Board Secretary
31.2. Developing systems for the management and reporting of risks and incidents	Chief Executive	Director of Corporate Governance/Board Secretary (risk) and Executive Director of Quality & Nursing (incidents)
32. Seal The keeping of a register of seal and safekeeping of the seal	Chief Executive	Director of Corporate Governance/Board Secretary
33. Signing of Documents		
33.1. Legal Proceedings/Advice		
(a) Engage Trust's solicitors/legal advisor	Chief Executive	Relevant Director
(b) Documents connected with legal proceedings[6]	Chief Executive	Relevant Director
33.2. Documents which are required to be executed as a Deed[7]	Chief Executive	Relevant Director and Director of Corporate Governance/Board Secretary
33.3. Other Agreements/Contracts not required to be executed as a Deed	Chief Executive	Relevant Director
33.4. Agreements/Contracts where award approved by Board	Chief Executive	N/A

6 May include but not be limited to consent orders, defences, and settlement agreements)
7 Refer to Governance Practice Note 001 for use of Trust Seal

Delegated Matter	Responsible Officer/Committee	Delegated To
33.5. Lease Agreements[8]	Chief Executive	Director of Finance and Corporate Resources and Director of Corporate Governance/Board Secretary
34. Security Management Provide an oversight and assurance within the context of security management within NHS Wales; working in conjunction with the following leads on specific functional areas of security management:		
34.1. Finance, fraud etc.	Chief Executive	Director of Finance & Corporate Resources
34.2. Estates, premises security etc.	Chief Executive	Director of Finance and Corporate Resources
34.3. ICT	Chief Executive	Director of Digital Services
34.4. Information/data security/records management	Chief Executive	Director of Digital Services
34.5. Violence and aggression	Chief Executive	Executive Director of Quality and Nursing
34.6. Patient Confidentiality	Chief Executive	Caldicott Guardian (Executive Director of Quality and Nursing)
35. Setting of Fees and Charges (Income)		
35.1. Income generation	Chief Executive	Executive Director of Finance & Corporate Resources
35.2. Non-patient care income (e.g., research)	Chief Executive	Executive Director of Finance & Corporate Resources
36. Stores and Receipt of Goods		
36.1. Responsibility for systems of control over stores and receipt of goods, issues and returns	Chief Executive	Relevant Director
36.2. Stocktaking arrangements	Executive Director of Finance & Corporate	(the relevant) Assistant Director of Finance

8 Copies of all leases are to be kept once signed by the Estates Manager for property related leases and by the Board Secretary for all other leases/contracts

Delegated Matter	Responsible Officer/Committee	Delegated To
	Resources	
36.3. Responsibility for controls of pharmaceutical supplies	~~Executive Director of Paramedicine~~Chief Clinical Officer	Heads of Department as appropriate
37. Workforce and Pay		
37.1. Nomination of officers to enter into staff contracts of employment	Chief Executive	~~Director of People~~Chief People Officer
37.2. Develop Workforce policies and strategies for approval by the Board including but not limited to training and industrial relations	Chief Executive	~~Director of People~~Chief People Officer ~~and Director of Culture Change~~
37.3. Renewal of Fixed Term Contract	Chief Executive	~~Director of People~~Chief People Officer
37.4. The granting of additional increments to staff upon initial appointment within the parameters of existing agreements	Chief Executive	~~Director of People~~Chief People Officer
37.5. Establishments		
(a) Additional staff to the agreed establishment with specifically allocated finance	Chief Executive	Executive Director of Finance & Corporate Resources/ ~~Director of People~~Chief People Officer
(b) Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	Executive Director of Finance & Corporate Resources/ ~~Director of People~~Chief People Officer
(c) Self-financing changes to the establishment	Chief Executive	Relevant Director
(d) Self-financing changes to an establishment which involves movement between pay and other types of expenditure	Chief Executive	Executive Director of Finance & Corporate Resources
37.6. Pay Preparation of proposals for the Trust Board for the setting of remuneration and conditions of service for those staff not covered by Agenda for Change	Chief Executive	~~Director of People~~Chief People Officer

Delegated Matter	Responsible Officer/Committee	Delegated To
37.7. Annual Leave		
(a) Approval of annual leave	Chief Executive	Relevant Directors
(b) Annual leave - approval of carry forward up to maximum of 5 days (and pro rata for part time staff)	Chief Executive	Relevant Directors
(c) Annual leave – approval of carry forward over 5 days (and pro rata for part time staff) (to occur in exceptional circumstances only)	Chief Executive	~~Director of People~~Chief People Officer / Executive Director of Finance & Corporate Resources
37.8. Special Leave To be applied in accordance with Trust Policy. Departure from policy will be as follows:		
(a) Compassionate leave	Chief Executive	~~Director of People~~Chief People Officer
(b) Special leave arrangements for domestic/personal/family reasons: • Paternity leave • Carers leave • Adoption leave	Chief Executive	~~Director of People~~Chief People Officer
(c) Special leave – this includes: • Jury service • Armed services • School governor To be applied in accordance with Trust Policy	Chief Executive	~~Director of People~~Chief People Officer
(d) Leave without pay	Chief Executive	~~Director of People~~Chief People Officer
(e) Time off in lieu	~~Director of People~~Chief People	Line/Departmental Manager

Delegated Matter	Responsible Officer/Committee	Delegated To
	Officer	
(f) Maternity leave – paid and unpaid	~~Director of People~~Chief People Officer	Automatic approval within approved guidance
37.9. Sick Leave		
(a) Extension of sick leave on pay due to: • Delays in process • Exceptional circumstances	Chief Executive	~~Director of People~~Chief People Officer
(b) Return to work part-time on full pay to assist recovery	Chief Executive	Heads of Department/Heads of Service in conjunction with People Services Business Partners
37.10. Study Leave	Chief Executive	~~Director of People~~Chief People Officer
37.11. Removal expenses, excess rent and house purchases in accordance with Table B	Chief Executive	~~Director of People~~Chief People Officer
37.12. Authorised – car users leased car	Chief Executive	Executive Director of Finance & Corporate Resources
37.13. Approval of secondary employment (also subject to a declaration of interest)	Chief Executive	~~Director of People~~Chief People Officer
37.14. Putting proposal to Remuneration Committee in respect of Redundancy/ Severance/ VERS/ Settlement Payments within Trust limits and, where necessary, subject to WG approval	Chief Executive	~~Director of People~~Chief People Officer / Executive Director of Finance & Corporate Resources
37.15. Disciplinary procedures (excluding Executive Directors)	Chief Executive	To be applied in accordance with the Trust's disciplinary procedure
37.16. Booking of bank staff		
(a) Nursing	Chief Executive	~~Executive Director of Quality & Nursing~~Chief Clinical Officer

Delegated Matter	Responsible Officer/Committee	Delegated To
(b) Clinical (excluding nursing)	Chief Executive	~~Executive Director of Operations~~Chief Operating Officer/ ~~Executive Director of Paramedicine~~Chief Clinical Officer
(c) Other	Chief Executive	Relevant Director
37.17. Booking of agency and locum staff		
(a) Nursing	Chief Executive	~~Executive Director of Operations~~Chief Operating Officer
(b) Medical	Chief Executive	~~Executive Director of Paramedicine~~Chief Clinical Officer
(c) Paramedicine and affiliated roles	Chief Executive	~~Executive Director of Operations~~Chief Operating Officer
(d) Other	Chief Executive	Relevant Director

Table B – Delegated Financial Limits

NB Thresholds are inclusive of VAT irrespective of recovery arrangements with the exception of procurement thresholds which are provided net of VAT.

NB Limits are based on the lifetime value of the individual contract award, not an annual or financial year value

	Category	Welsh Govt Delegated Limit - Approval Required[9]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of PeopleChief People Officer and Culture	Exec Director Quality and NursingChief Clinical Officer	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[10]
1.	**LOSSES**										
1.1.	**Losses of Cash** due to**:**										
(a)	Theft, fraud, arson, sabotage, neglect of duty or gross carelessness	50,000	Over 50,000[11]	50,000	10,000						See Annex 1 to Chapter 6 of Welsh Govt Manual for Accounts (WGMFA)
(b)	Overpayment of salaries, wages, fees & allowances	50,000	Over 50,000[8]	50,000	10,000						See Annex 1 to Chapter 6 of WGMFA
(c)	Other causes, including un-vouched or completely vouched	50,000	Over 50,000[8]	50,000	10,000						See Annex 1 to Chapter 6 of WGMFA

9 NHS Wales health bodies do not have unlimited powers to make special payments or to write-off losses. They must obtain the written approval of the Welsh Government HSCEY Finance Director before writing-off a loss or making, or undertaking to make, any special payment that exceeds their delegated limit. The limits are listed in this column.

10 These notes are intended to guide the reader. They must be read in conjunction with the SO/SoRD/SFIs and those related to losses and special payments with respect to the Welsh Government Manual of Accounts, as well as any relevant Governance Practice Notes.

11 Does not negate the need for WG Approval which is also required

Category	Welsh Govt Delegated Limit - Approval Required[9]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of PeopleChief People Officer and Culture	Exec Director Quality and NursingChief Clinical Officer	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[10]
payments, overpayments other than those included under 1b; physical losses of cash and cash equivalents e.g. postage stamps due to fire (other than arson), accident and similar cause										
1.2. Fruitless Payments, including abandoned capital schemes	250,000	Over 250,000[8]	250,000				100,000	50,000	10,000	A "fruitless payment" is a payment for which liability ought not to have been incurred, or where the demand for the goods and service in question could have been cancelled in time to avoid liability. See further info at annex 1 to Chapter 6 of WGMFA
1.3. Bad Debts and Claims Abandoned										See Annex 1 to Chapter 6 of WGMFA
(a) Private patients	50,000	Over 50,000[8]	50,000	10,000						
(b) Overseas visitors	50,000	Over 50,000[8]	50,000	10,000						
(c) Causes other than (a) and (b) above	50,000	Over 50,000[8]	50,000	10,000						
1.4. Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:										
(a) Culpable causes, e.g., theft, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000	Over 50,000[8]	50,000	10,000						

	Category	Welsh Govt Delegated Limit - Approval Required[9]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of PeopleChief People Officer and Culture	Exec Director Quality and NursingChief Clinical Officer	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[10]
	(b) Other causes	50,000	Over 50,000[8]	50,000	10,000						May include losses by fire (other than arson); losses by weather damage or by accident beyond the control of any responsible person; losses due to deterioration. See Annex 1 to Chapter 6 of WGMFA for further info
2.	**SPECIAL PAYMENTS**										
	2.1. Compensation payments under legal obligation	N/A	Board to be made aware of payment over 25K	Over 100,000	100,000	25,000	25,000				Payments fall into this category only if a clear liability exists as a result of a Court Order or a legally binding arbitration award. This category can include compensation for injuries to persons, damage to property and unfair dismissal. Payments into court, and out of court settlements, are not payments made under legal obligation.
	2.2. Extra contractual payments to contractors	50,000	Over 50,000[8]	50,000	10,000						An extra contractual payment is one which, although not legally due under the original contract or subsequent amendments, appears to be an obligation which the Courts may uphold. Such an obligation will usually be attributable to action or inaction by a health body in relation to the contract. See Annex 2 to Chapter 6 of WGMFA for further info
	2.3. Ex gratia payment										Ex gratia payments are payments which a health body is not obliged to make or for which there is no statutory cover or

Category	Welsh Govt Delegated Limit - Approval Required[9]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of PeopleChief People Officer and Culture	Exec Director Quality and NursingChief Clinical Officer	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[10]
										legal liability. An example is a payment to compensate for financial loss resulting from an act or failure of the body or its servants which does not give rise to a legal liability or the payment of compensation claims or damages. See Annex 2 to Chapter 6 of WGMFA for further info
(a) To patients and staff for loss of personal effects	50,000	Over 50,000[8]	50,000	10,000	10,000					
(b) For clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payment has been applied	1,000,000	Over 500,000[8]	500,000			100,000		50,000	10,000	Delegations are inclusive of plaintiff's costs. Many clinical negligence and personal injury cases are settled out of Court and are, therefore, classified as ex gratia payments. Provided the relevant guidance has been followed and appropriate legal advice has been obtained, in cases involving negligence the delegated limits are much higher than those which apply to other ex gratia payments
(c) For personal injury claims where legal advice obtained, and relevant guidance has been applied	1,000,000	Over 500,000[8]	500,000			100,000		50,000	10,000	Delegations are inclusive of plaintiff's costs. Many clinical negligence and personal injury cases are settled out of Court and are, therefore, classified as ex gratia payments. Provided the relevant guidance has been followed and appropriate legal advice has been

Category	Welsh Govt Delegated Limit - Approval Required[9]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of PeopleChief People Officer and Culture	Exec Director Quality and NursingChief Clinical Officer	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[10]
										obtained, in cases involving negligence the delegated limits are much higher than those which apply to other ex gratia payments
(d) Other clinical negligence and personal injury claims including Putting Things Right arrangements	50,000	Over 50,000[8]	50,000			10,000				
(e) Other[12] Except cases for maladministration where there was no financial loss by claimant	50,000	RemCom Over 50,000[8]	50,000		10,000					Other ex-gratia payments include: Voluntary Early Release Scheme payments which must be approved by RemCom regardless of value (SoR 25). Special severance payments when staff leave public service employment should be exceptional. They are usually novel contentious and potentially repercussive, and **ALL must be referred to WG for approval, even if they are within delegated limits** which must be approved by RemCom regardless of value (SoR 25) Settlements on termination of employment. Most payments to staff on termination of their employment will be contractual, but ex gratia payments will sometimes arise (for example to settle a claim against the health body for breach of contract). Only payments made in excess of that which is paid

12 ALL special severance payments (novel, contentious and potentially repercussive) of whatever value must be referred to WG for approval, even if they are within delegated limits

	Category	Welsh Govt Delegated Limit - Approval Required[9]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	~~Director of People~~Chief People Officer and Culture	~~Exec Director Quality and Nursing~~Chief Clinical Officer	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[10]
											under contractual obligation should be recorded as ex-gratia in the losses and special payments register. *These payments may be made by Chief Executive (up to £50K) and Executive ~~Director of People~~Chief People Officer (up to £10K) and reported to the next RemCom. They are also included in the report to AC on losses and special payments.
	(f) Maladministration where there was no financial loss by claimant	N/A	Over 50,000	50,000	10,000						In most cases of maladministration there is unlikely to be any legal obligation to pay compensation, and any payment would, as a result, be ex gratia. Such payments may arise: • as a result of a recommendation by the Public Services Ombudsman Wales (PSOW). • in cases, not involving the PSOW, where NHS Wales health bodies consider that the effect of official failure may justify a payment
	(g) Patient referrals outside UK and EEA guidelines	N/A	Over 50,000	50,000	10,000						
	2.4. Extra statutory and extra regulatory Payments	N/A	Over 50,000	50,000	10,000						These are payments considered to be within the broad intention of a statute or statutory regulation, but which go beyond a strict interpretation of its terms. In some cases, WG will advise to classify the payments as extra statutory.

	Category	Welsh Govt Delegated Limit - Approval Required[9]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of PeopleChief People Officer and Culture	Exec Director Quality and NursingChief Clinical Officer	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[10]
											In all other cases WG must be informed and will advise whether the payments may be treated as extra statutory See Annex 2 of WGMOA for more info.
3.	**REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENT** **NB: To ensure processes are efficient, timely and appropriately delegated, the Chief Executive with the endorsement of the Director of Finance and Corporate Resources will approve requisitions above £500K (or £200K for management consultants at 3.6 below) arising out of an award approved by the Board in accordance with the Scheme of Matters Reserved to the Board and after satisfying themselves that the requisition is aligned to the approval provided by the Board.**										
3.1.	**Agency staff and private providers**	N/A	See note above	500,000	200,000	200,000	200,000	200,000	50,000 (100,000 for Assistant Director of Operations, Ambulance Care for private providers only)	10,000	Any agency staff, including medical locums. No other managers can authorise use of agency staff.
3.2.	**Building and engineering works (non-capital)**	N/A	See note above	500,000	100,000	100,000	100,000	100,000	50,000	10,000	
3.3.	**Call off orders (annual value)**	N/A	See note above	500,000	100,000	100,000	100,000	100,000	50,000	10,000	High cost medical consumables, provisions, routine supplies, excluding locums or agency staff
3.4.	**Capital expenditure (subject to annual programme being approved by Trust Board)**	N/A	See note above	500,000	100,000	100,000	100,000	100,000	50,000	10,000	The Board to approve cases outside discretionary allowances. Capital programme agreed annually by Board.

Category	Welsh Govt Delegated Limit - Approval Required[9]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of PeopleChief People Officer and Culture	Exec Director Quality and NursingChief Clinical Officer	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[10]
3.5. Information Technology	N/A	See note above	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Major IT systems, software purchase, PC and printer purchase, networking, computer consumables. Includes software or hardware maintenance contracts
3.6. Management consultants (including professional services)	N/A	See note above	200,000	10,000	10,000	10,000	10,000			
3.7. Periodic payments (invoice value)	N/A	See note above	500,000 *750,000 for utilities/ fuel	100,000 *750,000 for utilities/ fuel	100,000	100,000	100,000	50,000	10,000	*In relation to Gas, Electricity, Council tax, Telephone, Water and Fleet Fuel invoices, due to the high level of expenditure on a recurring basis, payments up to a value not exceeding £750,000 can be authorised by the Director of Finance or the Chief Executive. For the provision of clarity, payments of PIBS (Personal Injury Benefit Scheme) invoices do not require authorisation on the basis that these quarterly payments are a reimbursement of pension payments made that have already been authorised.
3.8. Removal expenses	N/A	N/A			8,000					Allowance of £6,000 per relevant staff member
3.9. Services (including maintenance contracts) over lifetime of contract	N/A	See note above	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Routine maintenance contracts, clinical services (e.g. MRI), legal services, audit, clinical waste etc.
3.10. All other requisitions	N/A	See note		100,000	100,000	100,000	100,000	50,000	10,000	

	Category	Welsh Govt Delegated Limit - Approval Required[9]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of PeopleChief People Officer and Culture	Exec Director Quality and NursingChief Clinical Officer	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[10]
			above	500,000							
4.	**QUOTATIONS AND TENDERS**										
4.1.	**Authorisation of awards of tenders and competitive quotations**	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by these staff to the value of the contract. Detail provided here on quotations and tenders for ease of reference, but staff must refer to SFIs for further detail: Quotations- a minimum of 3 written quotations for goods/services must be sought where the anticipated value is likely to be above £5,000. Competitive Tenders- a minimum of 3 written competitive tenders for goods/services must be sought where the anticipated value is likely to be above £25,000. Tenders for Supplies and Services above the limit set EU Procurement matters for works above set limits must be sought in compliance with EC Directives (Updated Jan 2008) (OJEU Regulations) as appropriate. All Tenders and Quotations must be sought, registered, and opened via the SSP. These levels of authorisation may be varied or changed and need to be read

	Category	Welsh Govt Delegated Limit - Approval Required[9]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of PeopleChief People Officer and Culture	Exec Director Quality and NursingChief Clinical Officer	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[10]
											in conjunction with the Trust Board's Scheme of Delegation Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes. Where there is urgency board approval may be by way of Chair's Action in line with the SOs. Exceptions and Instances where formal tendering need not be applied will require authorisation in the form of a request to waive SFIs (pre numbered document from SSP) and authorisation in advance from the Director of Finance or the relevant Assistant Director of Finance (or in their absence the Board Secretary)
5.	**VIREMENT**	N/A	Over 100,000	100,000	25,000						Trust must still meet financial targets and the total Trust budget must remain underspent
6.	**LEASE AGREEMENTS**	**	Over 500,000	500,000	100,000 (with Board Secretary)						**See Schedule 1 to SFIs Copies of all leases are to be kept once signed by the Estates Manager for property related leases and by the Board Secretary for all other leases/contracts
7.	**BUSINESS CASES SEEKING EXTERNAL FUNDING**	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Any individual awards of contract that flow from approval of a business case must be approved in line with this Scheme of Reservation and Delegation

Category	Welsh Govt Delegated Limit - Approval Required	Board of Trustees/Trust Board	Charity Committee	Bids Panel	Bursary Panel					Notes
8. CHARITABLE FUNDS	N/A	N/A	Over 5,000	5,000	N/A					

Unless otherwise stated, sub-delegations to others are permitted. It is for individual Directors to ensure that a system of sub-delegations are in place for their respective directorates.

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs. Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.