Bundle Audit, Risk and Assurance Committee (Open) 2 December 2025

Agenda attachments
00 Agenda Audit Risk and Assurance Committee 2 December 2025 Open Meeting

09:30 - OPENING ITEMS

1 Chair's Welcome, Apologies and Quorum

2 Declarations of Interest
Item 02 Board Member Register of Interests - 18 November 2025

3 Minutes of the last meeting on 2 September 2025
Item 03 2025-09-02 ARAC OPEN Minutes unconfirmed

4.1 Action Log and Matters Arising
04.1 Action Log

4.2 Committee AAA Highlight Report 2 September 2025
Item 04.2 ARAC AAA Report 2 September 2025

4.3 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:35 - Internal Audit

5.1 Internal Audit Progress Report
Item 05.1 Internal Audit Progress Report December 2025

5.2 Internal Audit Reports

5.2.1 Mandatory In-Services Training (MIST) (Q2)
Item 05.2.1 Mandatory In-Service Training_Final Internal Audit Report
Item 05.2.1 amended Mandatory In-Service Training_Final Internal Audit Report_V2_Issued

5.2.2 Clinical Equipment (Q2)
Item 05.2.2 Clinical Equipment Final Internal Audit Report

5.2.3 Integrated Medium Term Plan (IMTP) Development Progress
Item 05.2.3 IMTP Development Process Final Internal Audit Report

6 10:20 - Audit Wales

6.1 Audit Wales Update Report
Item 06.1 Audit Comittee Update Report December 2025

6.2 Structured Assessment 2025
Item 06.2 Structured Assessment 2025
Item 06.2.1 Management Response Form

6.3 National Fraud Initiative 2024/25: Update for Welsh Ambulance Services University NHS Trust
Item 06.3 National Fraud Initiative 2024-25 WAST

6.5 11:20 - COMFORT BREAK

7 11:35 - Board and Committee Quality and Governance Reviews 2025/26
Item 07 Quality and Governance Review SBAR 041225
Item 07 Annex 1 QuEST Terms of Reference 2026-27
Item 07 Annex 2 PCC Terms of Reference 2026-27
Item 07 Annex 3 FPC Terms of Reference 2026-27

8 12:05 - Risk Management and Board Assurance Framework (including Risk Appetite Statements)
Annex 4 Board Assurance Framework is available in the Reading Room
Item 08 Executive Summary Risk Management Report ARAC 021225
Item 08 Annex 5 - Trending Data - Mar 2023-Nov 2025

9 12:20 - Audit Tracker 2025/26 Q2
Annexes are available to view in the Reading Room
Item 09 Executive Summary - Audit Tracker 25-26 Q2 (Jul-Sep25)

10 12:30 - Bi-annual Policy Report (progress against 2025/26 Policy Work Programme)
Item 10 Policy Report for ARAC 021225 Final

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

11.1 CONSENT ITEMS

12 Cycle of Business Monitoring Report and Priorities Update 2025/26
Item 12 Priorities & Cycle Monitoring Report December 2025
Item 12 Annex 1 Cycle of Business Monitoring Report 2025/26
Item 12 Annex 2 Cycle of Business Notes

12.1 12:40 - CLOSING ITEMS

13 Reflections and Summary of Decisions/Actions

14 Any Other Business

15 Date and Time of the next meeting: 2 March 2026

Length of Meeting:	03:15	Agenda Status:	[OPEN] AUDIT, RISK AND ASSURANCE COMMITTEE - 2 DECEMBER 2025					Deadline for Papers: 21 NOVEMBER 2025		Last good practice Exec Review: 26 November 2025
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**	**Further approval route (if app.)**
			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 on 2 September 2025	Paper	Approval	Standing	n/a	Chair	n/a	
		4	Action Log & Matters Arising: 4.1 Action Log 4.2 Committee AAA Highlight Report: 2 September 2025	Paper	Discussion	Standing	n/a	Chair	n/a	
			FOR APPROVAL, ASSURANCE AND DISCUSSION							
09:35	00:45	5	**Internal Audit** 5.1 Internal Audit Progress Report 5.2 Internal Audit Reports 5.2.1 Mandatory In-Service Training (MIST) (Q2) (Reasonable Assurance) (Carl Kneeshaw) 5.2.2 Clinicial Equipment (Q2) (Reasonable Assurance) (Andy Swinburn) 5.2.3 Integrated Medium Term Plan (IMTP) Development Process (Substantial Assurance) (James Houston)	Paper	Assurance	CoB	Internal Audit	Osian Lloyd	Felicity Quance	
10:20	01:00	6	**Audit Wales** 6.1 Audit Wales Update Report 6.2 Structured Assessment 2025 6.2.1 Structured Assessment Response Form 6.3 National Fraud Initiative 2024/25: Update for Welsh Ambulance Services University NHS Trust	Paper	Assurance	CoB	External Audit	Fflur Jones	n/a	
11:20	00:15		**COMFORT BREAK**							
11:50	00:30	7	Board and Committee Quality and Governance Reviews 2025/26	Paper	Endorsement	CoB	CorGov	Trish Mills	Jule Boalch, Alex Payne	
11:35	00:15	8	Risk Management and Board Assurance Framework (including Risk Appetite Statements)	Paper	Assurance	CoB	CorGov	Julie Boalch	Dan King	
12:20	00:10	9	Audit Tracker 2025/26 Q2	Paper	Assurance	CoB	CorGov	Trish Mills	Lisa Trounce	
12:30	00:05	10	Bi-annual Policy Report (progress against 2025/26 Policy Work Programme)	Paper	Assurance	CoB	CorGov	Trish Mills	Lisa Trounce	
12:35	00:05	11	Losses and Special Payments	Paper	Assurance	CoB	FinCor	(Chris Turley)Ed Roberts	Jessica Price	
			CONSENT ITEMS							
12:40	00:00	12	Cycle of Business Monitoring Report and Priorities Update 2025/26	Papers	Information	CoB	CorGov	Trish Mills	Sarah Harland	
			CLOSING ITEMS							
		14	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a	
12:40	00:05	15	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a	
		16	Date & Time of the next meeting: 2 March 2026	Verbal	Information	Standing	n/a	Chair	n/a	
12:45	**03:15**		**CLOSE**							

LEAD PRESENTERS

Name	Position
Julie Boalch	Assistant Director of Governance and Risk
Peter Curran	Non-Executive Director and Committee Chair
Fflur Jones	Audit Wales
Osian Lloyd	Head of Internal Audit
Trish Mills	Director of Corporate Governance/Board Secretary
Ed Roberts	Acting Director of Finance and Corporate Resources

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	**Non-Executive Director** * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1985		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	**Non-Executive Director** * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
BROOKS, Lee	**Executive Director of Operations**	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
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		
		Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022	17 July 2025	
		Chair - Taff Housing Association	Any Other Interest	17 July 2025		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022	31 October 2024	
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024	30 September 2025	
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015	January 2025	
		Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director - Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Chair - North Devon Homes	Position in Charity or Voluntary Organisation	01 October 2021	January 2025	
		Company Director - North Devon Homes	Directorships	01 April 2022		
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	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		
		Company Director - Springfield Property Lettings Ltd	Directorships	16 August 2022		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	*Directorships*	*12 March 2020*		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
EVANS, Bethan [continued]	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024		
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024		
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024		
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024		
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024		
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024		
		Company Director - The Mountains Property Ltd	Directorships	09 December 2024		
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	Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995	31 May 2025	
		Emeritus Professor, Swansea University	Non-Financial Professional	31 May 2025		
		Consultancy (temporary cover for the Director of Operations - Clinical Trials Unit) at Wolverhampton University	Financial Interest	10 October 2025	31 December 2025	
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROBERTS, Edward	**Interim Finance Director (from 09 September 2025)**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017	31 March 2025	
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023	2 June 2025	
		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	
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	**Trade Union Partner**	Nil Declaration				

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
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		
		External Moderator for HR Masters modules for University West of England	Financial Interest	September 2024		
		Member of Yoga Professional Alliance	Non-Financial Personal	July 2025		
		Sub-Yoga Teacher - Burnham Swim and Leisure Centre	Financial Interest	July 2025		

UNCONFIRMED MINUTES OF THE AUDIT, RISK AND ASSURANCE COMMITTEE OPEN MEETING HELD AT CARDIFF MRD AND REMOTELY VIA MICROSOFT TEAMS ON 2 SEPTEMBER 2025

MEMBERS PRESENT:

Peter Curran	Non-Executive Director and Committee Chair
Rhiannon-Beaumont-Wood	Non-Executive Director
Ceri Jackson	Non-Executive Director

PRESCRIBED ATTENDEES

Julie Boalch	Assistant Director of Corporate Governance & Risk
Christian Fox	Trade Union Representative
Fflur Jones	Audit Wales
Carl Kneeshaw	Director of People
Trish Mills	Director of Corporate Governance/Board Secretary
Osian Lloyd	Head of Internal Audit, NWSSP Internal Audit
Chris Turley	Executive Director of Finance & Corporate Services
Damon Turner	Trade Union Representative
Liam Williams	Executive Director of Quality & Nursing
Carl Window	Local Counter Fraud Manager

IN ATTENDANCE:

Peter Brown	Assistant Director of Operations, Operations Transformation
Jonathan Chippendale	Assistant Director of Clinical Development *(Item 11)*
Sarah Harland	Corporate Governance Officer
Estelle Hitchon	Interim Executive Director Planning & Performance/ Director of Partnerships and Engagement
Angie Lewis	Director of Culture Change *(Item 6.2.2)*
Amy Lord	Audit Wales
Elliot Miller	Operations Support Manager *(Item 6.2.1)*
Alex Payne	Corporate Governance Manager
Jessica Price	Deputy Head of Financial Accounting
Felicity Quance	Deputy Head of Internal Audit, NWSSP Internal Audit
Ed Roberts	Interim Assistant Director of Finance

APOLOGIES:

Judith Bryce	Assistant Director of Operations, National Operations & Support
Yvonne Thomas	Audit Wales

OBSERVING:

Dan King	Risk Manager

1. WELCOME, APOLOGIES AND QUORUM

1.1 The Chair welcomed members and apologies were noted.

1.2 It was confirmed the meeting met quorum.

The Committee RESOLVED to:
The apologies were noted, and the committee were assured the meeting was quorate.

2. DECLARATIONS OF INTEREST

2.1 No interests were declared.

3. MINUTES OF THE LAST MEETING 24 JUNE 2025

3.1 The Minutes from the meeting of the Audit Risk and Assurance Committee (ARAC) held on 24 June 2025 were agreed as a correct record with no amendments requested.

The Committee RESOLVED to:
The minutes of the open meeting held on 24 June 2025 were confirmed as a correct record.

4. ACTION LOG AND AAA HIGHLIGHT REPORT

4.1 The Action Log was considered.

4.2 The Committee AAA Highlight Report from the meeting held on 24 June 2025 was noted.

The Committee RESOLVED to:
Consideration was given to the Action Log and the Highlight Report from the meeting held on 24 June 2025 was noted.

5. STANDING FINANCIAL INSTRUCTIONS CHANGES: SOCIAL PARTNERSHIP AND PUBLIC PROCUREMENT ACT (2023)

5.1 Chris Turley explained that recent updates in public sector procurement legislation (across England and Wales) have led to changes in the Standing Financial Instructions (SFIs), particularly affecting procurement processes. Chris assured the committee that these changes will not significantly affect costs or the types of providers the Trust works with, but the primary impact is on process documentation and transparency, especially for the procurement function managed by Shared Services.

5.2 Chris reported that, alongside legislative changes, Shared Services have taken the opportunity to review and enhance their processes, introducing some improvements not directly tied to the new legislation.

5.3 Both Chris Turley and Ed Roberts clarified that the differentiation between in-scope and out-of-scope health services is more relevant to health boards as commissioners, not the Trust, since the Trust rarely procures health services directly. Ed emphasised that the Trust relies on Shared Services for procurement guidance, and in nearly all cases, the standard Procurement Act route will apply.

5.4 The committee acknowledged challenges, such as balancing financial constraints with social value and the ability of small and medium-sized enterprises (SMEs) to meet new requirements, but agreed the changes provide more tools to support the Welsh economy where possible. The committee endorsed the changes to Chapter 11 of the SFIs, which will then go to the Board for formal approval.

The Committee RESOLVED to:
The Committee endorsed the amendments to Chapter 11 of the Standing Financial Instructions and recommended progression to the Trust Board for Trust Board.

6.1 INTERNAL AUDIT PROGRESS REPORT

6.1.1 Osian Lloyd provided a progress update on the current audit plan, reporting that two final reports have been issued, six reviews are in progress and three are at the planning stage (further details are available in the appendix).

6.1.2 Osian confirmed that there are no concerns regarding the delivery of the plan at this stage. Additionally, Osian clarified a change in the plan focus, specifically confirming the scope for the capital audit, and referenced a separate agenda item for further detail *(Item 6.3)*.

6.1.3 Osian highlighted improved feedback return rates, which is due to the switch from word documents to electronic forms, and reported that all recent Key Performance Indicators are green, which indicates a good start to the year.

6.1.4 There was feedback that the graph in section 2 of the report was difficult to interpret, and it was suggested that it should be revisited to ensure it is easy to understand.

6.1.5 Finally, Osian invited the committee to note the progress and approve the confirmation of the scope for the Capital Provision audit. As stated in the report, this audit will focus on the Ambulance Replacement Programme, and it

will assess the Trust's arrangements for managing and controlling the refresh of the Trust fleet.

The Committee RESOLVED to:
The Committee noted the Report and approved the proposed changes at section 3 in relation to the scope of the Capital Provision audit within 2025/26.

6.2 INTERNAL AUDIT REPORTS

6.2.1 Manchester Arena Inquiry (MAI) – Substantial Assurance

6.2.1.1 Felicity Quance reported that the audit reviewed the Trust's progress in addressing recommendations, validating actions and governance arrangements. The review focused on 68 recommendations impacting the Trust, with a sample of 10 examined in detail. The audit found strong governance and proactive implementation, resulting in substantial assurance. One issue was noted regarding training compliance, though overall rates were acceptable for Emergency Medical Services (EMS) response. There were 18recommendations outstanding due to required financial investment, which have been referred for further funding consideration and are reflected in the risk register.

6.2.1.2 Peter Brown acknowledged the positive audit outcome and credited the team, especially Elliot Miller, for their work on the Manchester Arena recommendations. Peter added that monitoring of training compliance through senior leadership and EMS management groups is ongoing and advised that there is also ongoing engagement with Joint Commissioning Committee (JCC) and health board colleagues regarding outstanding recommendations.

6.2.1.3 Elliot Miller reported on recent engagement sessions with the JCC to present findings, with further follow-up sessions planned. The JCC is expected to provide answers on outstanding recommendations later in the year, and Elliot confirmed that actions are already underway to address the audit's training compliance issue, with remedial plans being developed. Elliot shared that Judith Bryce expressed satisfaction with the audit outcome and believes it will strengthen submissions to commissioners.

6.2.1.4 Rhiannon Beaumont-Wood enquired about plans for refresher Mandatory In-Service Training (MIST). Peter advised that the new 10-second triage approach encourages more frequent use of these skills in everyday incidents, helping maintain competence. Elliot Miller explained that the submission to commissioners included a request for additional funding for specific training and exercising for resilience and major incident response, as current resources and priorities limit internal delivery. Elliot also advised that Welsh Government is setting up a national programme for joint testing and

exercising among the tri-services (police, fire and ambulance), which will help staff practice these skills more frequently, especially in large scale incidents.

6.2.2 Organisational Change Policy (OCP) – Reasonable Assurance

6.2.2.1 Felicity Quance reported that the audit reviewed the Trust's processes for managing organisational change, focusing on compliance with national policy and employment legislation. Felicity advised that the People and Culture Directorate is handling approximately 100 active Organisational Change Processes; including 9 in one area and emphasised the need for better resource capacity to support effective delivery. The audit found that processes are developing, but require clearer guidance, improved planning, consistent application and better monitoring; including an OCP tracker. Felicity highlighted the need for structured learning and lessons learned to support continuous improvement.

6.2.2.2 Carl Kneeshaw welcomed the audit as a valuable opportunity to improve processes and foster a culture of continuous improvement in change management and confirmed acceptance of the audit findings and reported that work is progressing; with deadlines considered realistic given current resources and associated due dates. Carl emphasised the importance of lessons learned and measuring return on investment through quarterly post OCP reviews to assess outcomes and identify improvements. Carl added that this approach supports the Trust's organisational strategy, and that additional assurance will be provided through regular reporting to the People and Culture Committee, including staff survey feedback and updates on change initiatives.

6.2.2.3 Angie Lewis thanked NWSSP for running the audit and acknowledged the challenge of expanding the audit's scope from OCP processes to broader organisational change management. Angie appreciated the recognition that the Trust is at an early stage of embedding effective people change management and valued the challenge to focus on lessons learned and benefits realisation. Angie highlighted that over 75 people are now trained in change management techniques and expressed hope that a future audit would reflect a more strategic approach to change management beyond the formal OCP process.

The Committee RESOLVED to:
Noted the Manchester Arena Inquiry (MAI) and Organisational Change Policy (OCP) Internal Audit Reports and the committee were assured by the reports presented.

6.3 Proposed Amendment to the 2025/26 Internal Audit Plan

6.3.1 Trish Mills reported that following a review of the internal audit programme for this year, it is proposed that Clinical Prioritisation and Assessment

Software (CPAS) is audited in place of the planned Remote Clinical Support review, due to the number of high-level changes currently flowing through CPAS. It is proposed to postpone the Remote Clinical Support internal audit to the Q1 in 2026/27 internal audit programme.

6.3.2 Trish advised that it will be recommended that the following are reviewed to ensure that this is a robust and fit for purpose process that underpins the Trust's clinical transformation:

- Dispatch Cross Reference (DCR) Table Change Management Policy
- Request for change process
- Record keeping of changes for enquiries (Inc. coronary inquest)
- CPAS governance structure

6.3.3 Ceri Jackson asked for more context on the risks and rationale, emphasising the audit's connection to supporting patients at home and the importance of the CPAS system in the transformation agenda. Trish clarified that the audit would focus on the governance and workflow of CPAS, which is central to the Clinical Model Transformation, and offered to seek further details from Andy Swinburn if required.

6.3.4 Liam Williams explained that CPAS is critical for prioritising and assuring clinical transformation work and deferring the Remote Clinical Support audit allows more time for systemic changes to be embedded, improving future audit assurance. Peter Brown added that, over the past 18 months, the number of clinical systems overseen by CPAS has doubled, increasing complexity and risk, especially with new tools and innovative practices. This substantial change in the CPAS landscape justifies the audit's prioritisation.

6.3.5 . Following this discussion, and receipt of the additional context regarding the proposed amendment, the committee agreed to proceed with the proposed amendment to the 2025-26 internal audit plan to include the CPAS internal audit as opposed to the Remote Clinical Support.

The Committee RESOLVED to:

1. **Approved the change to the audit programme for 2025-2026 to cover CPAS instead of Remote Clinical Support.**
2. **Approved the transfer of the Remote Clinical Support audit to next year's audit programme plan.**

7. AUDIT WALES UPDATE REPORT

7.1 Amy Lord confirmed that the main annual financial audit was completed and reported to the committee in June 2025, and that there are no significant new updates on the accounts at this meeting.

7.2 Fflur Jones reported that the performance audit programme is progressing as planned, with the Structured Assessment nearing completion, and it is expected to be presented at the December committee meeting. Ongoing work includes national unscheduled care, local digital transformation and upcoming reviews of estates and non-emergency patient transport. Fflur also highlighted recent publications and a current consultation on the fee scheme, inviting feedback via a link in the paper.

The Committee RESOLVED to:
The Committee were assured by the Audit Wales Update Report.

8. RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

8.1 Julie Boalch introduced the Risk Management and Board Assurance Framework (BAF) report, outlining progress on the risk management programme, assurance on principal risk activity and an updated Risk Management Policy.

8.2 Dan King was also welcomed as the new Risk Manager and is already supporting work on evaluating an electronic risk management system for the next financial year.

8.3 Julie reported good progress on developing Risk Appetite Statements, which have been discussed at Strategic Transformation Board and Executive Leadership Team, and are scheduled for Trust Board approval following a development session.

8.4 Julie also provided an update that work is ongoing to differentiate between factors within and outside the Trust's control for key risks, specifically referencing risks 223 and 224. Julie explained that the template used for these risks is being applied to the decarbonisation risk, with collaboration with Joe Williams and Dan King. The next steps include exploring how to score internal and external factors separately, which will not affect the overall agreed risk score, but will provide more clarity on what is controllable. The output of this work is expected to be available in the next reporting cycle.

8.5 Julie reported no material changes to principal risks, and the current risk activity was recently reviewed by the Trust Board and ELT. Julie highlighted that new risks are forthcoming, and a reduction in the score for risk 160 *(High absence rates impacting on patient safety, staff wellbeing and the Trust's ability to provide a safe and effective service)* is anticipated. Trending data on risk scores was presented, with plans to develop a heat map for better visualisation. Julie clarified that risks dropping off the trending data are either mitigated/closed or transferred to directorate risk registers, and she will improve clarity around this in future reports.

8.6 Estelle Hitchon highlighted that the reputational risk (risk 201) has remained high and suggested disaggregating it into separate risks for patient harm and stakeholder/political issues, as their scores and mitigation may differ. Trish Mills and Rhiannon Beaumont-Wood emphasised that adopting risk appetite statements will help contextualise risk trends and improve interpretation of risk data.

8.7 Rhiannon also raised the importance of reviewing the likelihood assessment for 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)*, given its prominence on global risk registers. Julie responded that there had been a robust conversation at ELT about testing the likelihood and impact if the cyber risk were to materialise. Julie gave assurance that actions are in place and potential additional measures were discussed, and while she could not comment on technical details, Julie confirmed that the ELT had thoroughly considered the risk. Julie added that the detailed risk information is included in the closed session, but a high-level update is provided in the open session.

The Committee RESOLVED to:

1. **Received assurance on progress of the 2025/26 Risk Management work programme and timelines.**
2. **Reviewed the six draft Risk Appetite Statements ahead of Board Development Day on 19 September 2025.**
3. **Noted the continued work on repositioning of Risk 223 and 224.**
4. **Received assurance on the review and attention to the principal risk, including their review at ADLT, ELT and at relevant Committees.**
5. **Noted the rating and mitigating actions for each principal risk.**

8.1 RISK MANAGEMENT POLICY

8.1.1 Julie Boalch introduced the Risk Management Policy, explaining there were only minor changes around committee and job titles, with no content changes. The committee endorsed the Risk Management Policy for Trust Board approval.

The Committee RESOLVED to: Endorsed the Risk Management Policy for approval by Trust Board.

9. 2025/26 EFFECTIVENESS REVIEW, INCLUDING PROGRESS FROM PART II 24/25 REVIEW

9.1 Trish Mills presented the 2025/26 effectiveness review update, explaining that the process started early this year to streamline committee structures and better align them with strategic objectives and the Board Assurance Framework (BAF). The review builds on the comprehensive 2024/25 part II review, which was in-depth and mapped committees to strategic objectives.

9.2 Early assessment suggests no changes are needed for the Charity and Remuneration Committees, minimal changes for People & Culture and Quest, but more significant changes are likely for the Finance & Performance and Audit Risk and Assurance Committees, especially regarding research and innovation responsibilities if the Academic Partnership Committee is discontinued.

9.3 The review also includes updating the skills matrix to actively consider the composition of the committees and whether any changes are required. Any changes will not be implemented until April 2026. For this year, the effectiveness review will be more streamlined, focusing on two questions for each committee; what works well and what doesn't, in addition to views on terms of reference and membership.

9.4 The review will be renamed as a 'Quality and Governance Reviews' to reflect the requirement for the Trust to apply the Duty of Quality and our approach to continuous improvement. Trish will bring an update to the committee in December, before proposals are taken to the Trust Board for approval early in 2026.

The Committee RESOLVED to:

1. **Noted the update and progress.**
2. **Agreed that this current review of committee remits together with a simple questionnaire of all committees in Q3 constitutes the 2025/26 effectiveness review, now referred to as Quality and Governance Reviews.**

10.1 INTEGRATED GOVERNANCE PROGRAMME
THE DYNAMIC INTEGRATED SYSTEM OF GOVERNANCE AND OVERSIGHT

10.1 Trish Mills updated the committee on progress with the Integrated Governance Programme, highlighting completion of Q1 deliverables, including the rollout of new report templates and writing guidance. Trish highlighted that a mixed use of old and new templates will continue temporarily, but full adoption is planned from April 2026.

10.2 Work on Q2 deliverables is underway, and the main focus is now on developing the integrated governance handbook for Q3, which will clarify accountability arrangements and map governance and assurance frameworks. Trish invited committee feedback on the proposed structure and direction of the handbook, which will be further developed with member input and brought back in March 2026.

10.3 The Chair expressed strong support for the Integrated Governance Programme, commending the team's work and its potential value for the organisation.

10.4 Rhiannon Beaumont-Wood enquired about opportunities for Non-Executive Directors to use AI tools to support their roles, Trish confirmed that AI for governance is included in the programme, with a Board Development session planned later in the year.

The Committee RESOLVED to:

1. **Received assurance on progress of the programme and the 2025/26 deliverables and noted the roll-out of the new report templates and writing guidance.**
2. **Provided feedback on the direction of travel and outline of the IGP handbook.**

10.2 MID YEAR REVIEW OF CHANGES TO COMMITTEE OPERATING ARRANGEMENTS

10.2.1 Trish Mills provided an update on the mid-year review of changes to committee operating arrangements, which stem from the 2024-25 board and committee effectiveness reviews. The report confirms that progress is on track, with most planned changes being implemented as scheduled.

10.2.2 One exception to this is the paper on the 'Three Lines of Defence' in which had been planned for completion in October 2025; which will now be incorporated into the forthcoming integrated governance handbook to avoid duplication. The review highlights that all other committee changes are proceeding as planned, and the committee was asked to note and take assurance from this progress update.

10.2.3 Trish Mills queried with Chris Turley whether the new finance dashboard is being developed as a local initiative or as part of a sector-wide standardisation, and questioned its usefulness and the likelihood of a national solution versus developing their own. Chris Turley explained that it is a bit of both: there is ongoing work across Wales to refresh the financial system, but it's not mandated. The Trust has been working on its own dashboards for continuous improvement and value, aiming for more dashboard-based reporting at board and committee levels. Ed Roberts explained he has advocated for a standardised, "one version of the truth" dashboard across NHS Wales, with automatic monthly reporting, however, this has been delayed several times. If there is no national outcome soon (likely by Christmas), the Trust will develop its own internal dashboard, as many NHS Wales trusts currently use custom dashboards.

The Committee RESOLVED to: Reviewed and discussed the bi-annual update on agreed changes to operating arrangements for the board and committees for 2025/26 and were assured from the update provided on the progress against the actions.

11. AUDIT TRACKER 2025/26 QUARTER 1

11.1 Trish Mills updated the committee on the Audit Tracker Quarter 1 (Q1), which highlighted a reduction in closure rates for internal audit actions (23% in Q1 compared to 51% in Q4), but a significant improvement in closing actions on time (70% in Q1 versus 26% in Q4), reflecting more realistic implementation dates. The tracker anticipates a busy Q3 and Q4 due to actions scheduled for completion and new audits commencing.

11.2 Updates were provided on actions at their final revised date as follows:

11.2.1 Audit Action 635 111 *(Commissioning Final Advisory Report)*
The committee agreed that the current JCC structures and roles provide better clarity and assurance than the previous arrangement, and if all are satisfied, the action can be closed.

11.2.2 Audit Action 035-24/25 *(Exposure to Fumes)*
Liam Williams reported that the revised completion date for the diesel emissions action is set for December 2025 and expressed confidence in meeting this deadline. Liam explained that some outstanding actions are due to the need for board development days, and the creation of materials by the provider SOCOTEC UK, which has been secured. Additional work is required on the data build, with the team focused on Phase 1 Clinical Model Transformation implementation, and Liam plans to verify progress. Liam also shared positive news that the Trust is currently experiencing the lowest levels of handover delays in many years, which relates to the root cause of the diesel emissions issue.

11.2.3 Audit Action 701 *(Clinical Audit)*
Jonathan Chippendale explained that the action regarding the inclusion of clinical audit in communications is delayed due to the undecided publication platform for the clinical plan. However, all the required content for the clinical audit section is already written and available. Jonathan suggested that sharing this content now could satisfy the audit action, with formal publication to follow once the platform is finalised. The Chair asked for the timeline for publication, and Jonathan clarified that while the publication date is uncertain, the content is ready and can be shared immediately. The committee agreed that Jonathan Chippendale should share the written content for the clinical audit section as evidence to satisfy action 701, and that the action would be formally closed at the next (December) meeting once this evidence is reviewed.

11.2.4 Audit *Actions* 681/683/684/686/003-24/25 *(Electronic Patient Care Records ePCR) Clinical Compliance*
No update was provided on these outstanding actions, and it was asked that the Finance and Performance Committee consider the position at its upcoming meeting, instead.

11.3 Trish Mills explained that some audit actions, specifically those under paragraph 18, were incorrectly included in the tracker because they had already been closed. Trish clarified that the follow-up audit each year reviews closed actions to ensure they are appropriately closed, and there was a misalignment where these actions were mistakenly put back on the tracker. Trish apologised for the error and confirmed that these actions should not have been reopened

11.4 Progress on external audit actions was also noted, with 45% closure and revised dates for Welsh Risk Pool actions managed to avoid overloading teams.

11.5 Trish Mills asked committee members to review paragraph 32, which outlines the Power BI reporting being developed for the audit tracker, and to provide feedback on whether the proposed reporting is appropriate or if they would like more or less information included, as this is the stage when adjustments can be made before finalising the SharePoint list and Power BI dashboard. Trish emphasised that this feedback is important now, as the reporting structure is being built, but noted that it is not set in stone and can be adjusted if needed. Trish also clarified that the reporting will cover both internal and external audit actions. In response to Trish's question about Power BI reporting, it was suggested that the reporting should include both internal and external audit actions, this was noted as an observation to ensure comprehensive coverage in the dashboard. No other specific suggestions or requests for changes to the reporting were made by the committee at that time.

The Committee RESOLVED that:

1. **Noted the significant progress made in closing audit actions by their first date during 2025/26 Q1.**
2. **Noted and discussed the 12 internal audit actions for which final revised dates have been applied in quarter, and updates from the Directors responsible for these audits.**
3. **Noted the first revised dates applied to 17 of the 32 external audit actions related to the Welsh Risk Pool (WRP) Concerns Assessment 2024.**
4. **Received assurance that the management of actions for the audits within the purview of this Committee (at Annexes 2a- 2c in the reading room), and overall (at Annexes 1a-1d in the reading room, are**

being effectively and appropriately managed, closed off in quarter or clarity provided on dates which have moved and rationale.

12. POLICY REPORT (Bi-annual)

12.1 Trish Mills introduced the six-monthly update on the policy report and advised that the number of policies on the priority list decreased from 62 to 55 after Executive Leadership Team (ELT) review, with 7 deferred to next year. Trish acknowledged some slippage in the programme, particularly in the first two quarters, but stated that most delayed policies now have new dates set within governance processes. The expected completion rate is now around 85%, rather than the original 95%, due to workload shifting to later Quarters. Compliance within date policies has improved from 14% to 46% and is projected to reach 50% after upcoming committee approvals, with governance and escalation processes in place to monitor progress.

12.2 Rhiannon Beaumont-Wood sought clarification on the Quality Assurance Framework for the Clinical Desk policy, specifically regarding clinical risk exposure during its deferral. Peter Brown explained that the main reason for deferring the Quality Assurance Framework for the Clinical Desk policy is the ongoing replacement of Clinical Support Desk with the new Remote Integrated Care Service (RICS), which will be ready in quarter 4. Peter clarified that the current (extant) policy and arrangements will remain in effect until the new one is implemented, and the team's efforts are focused on ensuring that the new policy is ready for the future service.

12.3 The Chair accepted the revised target as reasonable and expressed confidence that remaining policies would be caught up next year, however an update on the policy programme was requested for the meeting on 02 December 2025, rather than waiting until the end of the financial year.

The Committee RESOLVED to:

1. **Noted the adjustment to the 2025/26 Policy Work Programme and that the review dates of several high priority policies are being recalibrated.**
2. **Received assurance on the progress to bring the Trust's Policies up to date and requested an update at the meeting on 2 December 2025.**
3. **Noted the direction of travel of the Policy Transformation Programme and requested an update at the meeting on 2 December 2025.**

13. ASSURANCE TO ARAC ON SPEAKING UP SAFELY FRAMEWORK (FROM CHAIR OF PEOPLE AND CULTURE COMMITTEE)

13.1 As Chair of the People and Culture Committee, Ceri Jackson provided assurance to the committee on the delivery of the Speaking Up Safely framework, highlighting significant progress in embedding a culture where staff and volunteers can raise concerns confidentially. The Trust appointed a

full-time lead Speaking Up Safely Guardian, which has been pivotal in advancing the policy, and staff can now speak up through various channels.

13.2 Rhiannon enquired about the structure of the Speaking Up Safely guardians, specifically if there are local champions in addition to the dedicated lead guardian, and how these roles function within the organization. Carl Kneeshaw responded that currently there is a lead guardian, recruitment is underway for an additional guardian, and there is administrative support, aiming for a team of three guardians as considered best practice for ambulance services. Carl explained that while the plan is to eventually have local champions, the approach is to build incrementally, ensuring alignment with other staff networks and avoiding duplication or undermining of line managers.

13. Rhiannon also highlighted the importance of clear pathways and signposting for staff, and asked about the target number of formal guardian roles. Carl reiterated the evolving nature of the model, the importance of signposting, and the need to balance local champions with existing support structures.

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

14. ASSURANCE TO ARAC ON NEAR MISS AND LOW HARM INTELLIGENCE FRAMEWORK (FROM CHAIR OF QUEST COMMITTEE)

14.1 As Non-Executive Director Member of the QuEST Committee, Ceri Jackson provided assurance to the committee on the near miss and low harm intelligence framework, on behalf of the Chair, Bethan Evans.

14.2 Following discussion regarding concerns around the identified challenges, the committee were not assured of the position due to what was articulated in the paper. The resulting agreement was to feed back to Bethan and to bring a further update in March 2026.

14.3 The Chair insisted on a six-month update for ongoing oversight, therefore Trish Mills suggested that, instead of scheduling a fixed six-month report to ARAC, the committee should use the AAA (alert, advise, assure) process to formally request Quest to keep the Putting Things Right recovery plan and related near miss/low harm reporting under review, with an action for an update in six months. This would allow Quest to escalate any concerns or lack of progress to ARAC as needed, ensuring the issue remains visible and appropriately monitored.

The Committee RESOLVED that:

1. **Members considered the current position, and the concerns arising from this regarding the Trust's current ability to adequately record and report near miss and low harm incidents.**
2. **Members noted the Committee's receipt of the PTR Organisational Recovery Plan as part of its ongoing scrutiny of the issue, and it was agreed the committee will receive a six-month update for ongoing oversite at the meeting on 2 March 2026.**

15. LOSSES AND SPECIAL PAYMENTS

15.1 Chris Turley provided a summary of the losses and special payments report for the period from 1 April 2025 - 31 July 2025 and reported as being -£1.812 million. Chris explained that this relates to actual payments made, less the reimbursements received from the Welsh Risk Pool, and does not relate to any adjustments made to the provision. During the 4-month period to July 2025 the reimbursements received exceeded payment made by £1.812m.

The Committee RESOLVED to:
Noted the Losses and Special Payments Report.

16. CYCLE OF BUSINESS MONITORING REPORT AND PRIORITIES UPDATE 2025/26

16.1 The Committee's Cycle of Business Monitoring Report and Priorities update were noted.

The Committee RESOLVED to:
Noted the Cycle of Business Monitoring Report and Priorities Update.

17. ALL-WALES AUDIT COMMITTEE CHAIR'S REPORT 2024/25

The All-Wales Audit Committee Chair's (AWACC) report was received, which reflected on activity over the last year. Peter Curran, Chair of ARAC, has taken over the Chair of AWACC for 12 months and will consider a reset to the group's approach following a survey of members and their expectations for its remit.

The Committee RESOLVED to:
The All-Wales Audit Committee Chair's Report 2024/25 was received.

18. JOINT DIRECTORATE NOTICE (Ref: 006-25)

20.1 The Joint Directorate Notice was received for information. Chris Turley clarified that the notice was a recommendation from a previous internal audit advisory report, and that many recommendations had been addressed through this.

20.2 Rhiannon Beaumont-Wood enquired about monitoring the impact on individuals assigned as contract managers, expressing concern about whether the responsibility might disproportionately affect some people, and also asked about the total number of contracts involved.

20.3 Chris Turley advised that the focus is on areas of the business with fewer contracts, not those with established processes, estates or digital, and that the intent is to ensure coverage in areas where contract management is not a dedicated role but part of broader responsibilities. Rhiannon acknowledged the explanation and emphasised the importance of monitoring for unanticipated impacts.

The Committee RESOLVED to:
The Joint Directorate Notice (Ref:006-25) was received.

19. REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

19.1 The Chair reflected that the meeting was very open, with lively discussion, and acknowledged the continued maturity in risk management and integrated governance. The Chair also highlighted the value of the internal and external audit reports and was pleased to see progress, especially with many items in the "green."

19.2 Ceri Jackson praised the excellent and succinct reporting, which positively impacted the discussion, and highlighted significant progress and ambition in governance. Rhiannon Beaumont-Wood agreed it was an excellent meeting, emphasising the benefits of working in partnership with auditors to support continuous improvement and the value of using audit to its full potential.

20. ANY OTHER BUSINESS

20.1 None declared.

21. DATE OF THE NEXT MEETING

21.1 The next meeting is scheduled for the 2 December 2025.

The meeting closed at 12:45pm

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
6.2/24062025	24 June 2025	Urgent and Emergency Care Report	Fflur Jones to provide a realistic date for the completion of the National View Report on Collaboration Handover between organisations.	Fflur Jones	2 September 2025	**Update 21 November 2025 from Fflur Jones** Deferred from December meeting as not yet finished, included in Forward Planner for March 2026 meeting. **Update 21 August 2025 from Fflur Jones:** Audit Wales is currently in the process of scoping a national output for urgent and emergency care services, including meeting with various stakeholders. Audit Wales anticipates this output will be completed by the end of the 2025 calendar year.	Open
12.3/02092025	2 September 2025	Policy Report (bi-annual)	It was requested at the meeting on 2 September 2025 that an update on the policy programme will be provided at the meeting on 2 December 2025, rather than waiting until the end of the financial year (added to forward planner)	Trish Mills	2 December 2025	Included within the 2 December 2025 Agenda.	Complete
14.2/02092025	2 September 2025	Assurance to ARAC on Near Miss and Low Harm Intelligence Framework	Trish Mills suggested that, instead of scheduling a fixed six-month report to ARAC, the committee should use the AAA (alert, advise, assure) process to formally request Quest to keep the Putting Things Right recovery plan and related near miss/low harm reporting under review, with an action for an update in six months. This would allow Quest to escalate any concerns or lack of progress to ARAC as needed, ensuring the issue remains visible and appropriately monitored	Trish Mills	2 March 2026	**Update 4 November 2025** The QuEST Committee received a AAA from ARAC regarding Near Miss and Low Harm Intelligence Reporting.	Not Due

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	25 September 2025
Committee Meeting Date	02 September 2025
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. The revised **Standing Financial Instructions** (SFIs) were reviewed by the committee and are **before the board at this meeting for approval**. Amendments were made to Chapter 11 (procurement section) of the SFIs by Welsh Government in response to the Procurement Act 2023 and the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and their associated subordinate instruments. The changes align with broader governmental objectives, such as the Future Generations Act, aiming to embed well-being and sustainability into procurement decisions. The NHS Wales Shared Services Procurement team have now introduced new processes to ensure the Trust's procurement processes align with the legislation and the SFIs. The Trust is working with procurement to embed the internal processes with further training, where required, being developed.

2. Oversight of **near miss and low harm intelligence reporting** sits with the Quality, Patient Experience and Safety Committee (QuEST). ARAC receives annual assurance, similar to the approach taken with the Speaking Up Safety report, aligned with HFMA guidance. The latest assurance report from the Chair of QuEST provided only limited assurance, citing ongoing challenges within the Putting Things Right (PTR) Team to progress cultural work necessary to improve near miss reporting. Specifically, the PTR team are dealing with continued high levels of demand resulting from system pressures and increased investigation complexity. ARAC noted comments from the Executive Director of Quality and Nursing that the immediate priority is the PTR recovery plan to improve statutory and regulatory compliance. As a result, improvements in near miss and low harm reporting may not be forthcoming in the short term. ARAC has asked QuEST to keep this issue under active review and ensure it is not lost within the wider PTR recovery work. An update will be provided in six months, rather than waiting for the annual assurance cycle.

3. The **Risk Management Policy** (attached at Annex 1) was endorsed for approval by Trust Board. There were non-material updates to the policy.

ADVISE

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

4. A **pre-meet** was held with Audit Wales, Internal Audit and the committee Non-Executive Directors ahead of the meeting.

5. Following its 2024/25 effectiveness review, this committee (ARAC) initiated a **strategic assessment of the Trust's governance framework** to ensure it remains proportionate, aligned and fit for purpose. This is also a committee priority for 2025/26. This work responds to concerns around committee structure, meeting volume and increasing Non-Executive Directors in attendance, particularly for quoracy. The aim is to streamline oversight while maintaining assurance. Early mapping against strategic objectives suggests minimal change to the People and Culture, QUEST, Charity and Remuneration Committees, with more substantive proposals under consideration for the Finance and Performance Committee and ARAC. Pending options being presented to ARAC in December, which may include transferring the remit of the Academic Performance Committee (APC) to other committees, APC will continue to meet through 2025/26 to oversee the research portfolio and support the embedding of the Health Care Research Wales governance framework. ARAC agreed that the term "effectiveness reviews" be replaced with "quality and governance reviews," going forward to better illustrate their purpose.

6. The **All-Wales Audit Committee Chair's (AWACC) highlight report** was received, looking back at the activity over the last year. Peter Curran, Chair of ARAC, has taken over the Chair of AWACC for 12 months and will consider a reset to the committee's approach following a survey of Members and their expectations for its remit.

7. Members **reflected** that the meeting was open and lively, with recognition of ongoing maturity in risk management and integrated governance. The quality and succinctness of the reports were highlighted as supporting effective discussion, and there was acknowledgment of visible progress in audit work and governance. Overall, the session was viewed as very positive, with clear advancements in key areas, and with effective chairing.

ASSURE

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

8. **Audit Wales** confirmed that the main annual accounts audit had been completed and presented at the previous committee meeting, with no issues identified, and the Trust was commended for achieving a balanced financial position and strong financial management. The 2025/26 Structured Assessment is underway, with the deep dive for 2025/26 being a review of the arrangements to manage estates (due to be reported in March 2026). A review of NEPTS is also planned for later in the year. The deep dive review of investment in digital systems to support service resilience and transformation is also underway, with the Trust recently completing a self-assessment to inform the work. It is anticipated that the Structured Assessment and the Unscheduled Care Output Report will be available for the December ARAC meeting. A helpful link for board members with respect to cost savings arrangements was shared and is here for reference: Cost Savings Arrangements: A Checklist for NHS Board Members.

9. **Internal Audit** reported good progress against the 2025/26 plan with all KPIs showing as green. The following changes to the plan were agreed by the committee:

   (a) The scope of the capital provision audit has now been confirmed as a focus on the Ambulance Replacement Programme.

   (b) The audit planned for Remote Clinical Support will be replaced with a review of the Clinical Prioritisation and Assessment Software (CPAS) Group (the governance and workflow). This is due to the number of high-level changes currently flowing through CPAS with the implementation of the Clinical Model Transformation Programme. The Remote Clinical Support audit will take place in Q1 2026/27. Members were assured that these changes were appropriate.

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

- **111 Website – Limited Assurance**. This is the last audit for the 2024/25 audit plan and had been delayed due to resourcing issues. It was taken in closed session due to the sensitive nature of management actions. The purpose of the review was to assess whether the 111 Wales website enables secure and effective provision of patient services. Members noted that the business case for recurrent resources has been submitted to Welsh Government and is key for several of the mitigations in a recently developed corporate risk for the website. The Finance and Performance Committee will discuss the audit in more detail at their September meeting.

- **Manchester Arena Inquiry – Substantial Assurance**. The purpose of this review was to review the progress made by the Trust to address and learn from the recommendations raised from the Manchester Arena Inquiry; and to assess the governance and reporting arrangements established, including a validation exercise to support the closure of actions.

  One medium-priority recommendation relating to MIST training was considered appropriate and will be monitored via the tracker by the Finance and Performance Committee. ARAC was able to take substantial assurance from the approach adopted by the team undertaking work connected to the MAI recommendations, including their logging of activity, approvals by relevant and necessary fora, and the evidence retained in support of concluding recommendations. Eighteen recommendations requiring financial investment have been referred to the Joint Commissioning Committee (JCC), with further discussions planned in the coming months. Members noted that the Trust remains at risk should a major incident occur before funding decisions are made, as some recommendations cannot be implemented without additional resources.

- **Organisational Change – Reasonable Assurance**. The purpose of this review was to evaluate the processes in place within the Trust to effectively manage organisational change. The audit found that organisational change processes are developing but need clearer guidance, better planning, consistent application, and improved monitoring. A high-priority finding and several medium-priority findings were accepted by management, with appropriate actions planned.

The importance of embedding lessons learned and benefits realisation through regular post-change reviews was emphasised, as was the need to view organisational change through a risk lens, highlighting the cumulative impact of multiple changes (both transformational and business-as-usual) on staff and the organisation. A heatmap is in development to visualise where change is concentrated and its potential risks. Members heard that the new tracker and checklist will help triangulate data and enable early, proactive mitigation of risks, such as increased staff turnover or attendance issues linked to change. People partners will play a key role in sharing information and identifying early warning signs. The People and Culture Committee will have oversight of these audit actions.

11. The Trust continues to progress its **Integrated Governance Programme**, which aims to streamline and unify governance structures and practices from 'floor to board'. Following the initial framework and tiering principles presented to ARAC in March 2025, the programme has moved into its next phase, focusing on practical tools and cultural improvements to enhance governance consistency, clarity, and accountability across the organisation.

    New front covers and SBARN templates were well received by the committee as was the writing and presentation guidance. The committee reviewed and endorsed the outline of the Accountability, Assurance and Governance Handbook which is a new resource for the Trust. This Q3 deliverable brings together, for the first time, a comprehensive view of our governance, risk and assurance arrangements, and provides practical tools and guidance to strengthen governance capability across all levels.

12. The committee received annual assurance from the Chair of the People and Culture Committee (PCC) regarding the Trust's **Speaking Up Safely** framework**.** Similar to the near miss report above, oversight of Speaking Up Safely sits with PCC, with annual assurance provided to ARAC aligned to HFMA guidance. This report demonstrated significant progress in embedding a culture that enables staff and volunteers to raise concerns confidentially, supported by the appointment of a full-time lead Guardian. The committee took assurance from the robust processes in place, and the ongoing commitment to further develop the framework, while recognising that achieving sustainable culture change is a long-term ambition. The committee will continue to monitor progress through regular reporting and engagement with the lead Guardian and People and Culture Committee.

13. The Trust's **policy work programme for 2025–26** has been revised from 62 to 55 policies following the deferral of seven items due to team capacity and interdependencies. While the original compliance target was 95% by March 2026, current projections suggest an achievable rate of 85%, with further review planned in Quarter 3. Notwithstanding the current slippage in the programme, the committee noted that progress remains positive, with compliance improving from 14% in September 2023 to a projected 50% in Quarter 3. ARAC will receive an update on that trajectory in December.

14. In May 2025 the board received a list of **changes to operating arrangements** for the board and its committees following the 2024/25 effectiveness reviews. There has been good progress, and no escalations were made.

15. The **Losses and Special Payments** were reviewed for the period from 01 April – 31 July 2025 and noted as being -£1.812 million. This relates to actual payments made, less the reimbursements received from the Welsh Risk Pool and does not relate to any adjustments made to the provision. During the four-month period to July 2025 the reimbursements received exceeded payment made by £1.812m.

16. The committee received the **Q1 2025/26 Audit Tracker** update. While the closure rate for internal audit actions fell to 23 percent (from 51 percent in Q4), there was positive progress in actions being closed on time and fewer revised deadlines, indicating more realistic initial timeframes. Forty-five percent of external audit recommendations were closed during the quarter. Twelve internal audit actions reached their final revised deadlines. Directors or deputies attended to confirm these dates are achievable and that associated risks are not worsening. One action, relating to 111 Commissioning, was closed during the meeting

17. The committee's **cycle of business monitoring report** was reviewed with no matters to escalate.

18. In private session the Committee received **the Local Counter Fraud** update report for the period 01 April 2025 to 31 July 2025. This report included a summary report from the NHS Counter Fraud Authority (NHSCFA) engagement visit in March 2025 and a related action plan. This engagement report provided assurance to the committee on the proposed actions to be completed by the Local Counter Fraud Service to address the NHSCFA recommendations from this visit. The counter fraud update included a summary of ongoing investigations: 11 cases have been closed in this period, with seven new referrals having been received. Additionally, **the tender update and single tender awards** were also received in private session, as was the audit tracker related to the Technical Resilience and Cyber Security Internal Audit recommendations.

RISK MANAGEMENT

19. The risk report was received which describes key elements of the **2025/26 risk management work programme** for committee's oversight. Members were assured in respect of the **Trust's principal risks** with no material changes this period. The full Board Assurance Framework (BAF) is available in the reading room.

20. Triangulation of the Manchester Arena Inquiry (MAI) Internal Audit Report against **Risks 594 and 641** were included noting ongoing discussions with the Joint Commissioning Committee to resolve the outstanding recommendations from the MAI Inquiry. Similarly, the Organisational Change Internal Audit Report was contextualised against **Risks 160, 163 and 558** in relation to sickness absence, trade union relationships, staff wellbeing and burnout seen as key factors in change management.

21. Members were assured that, despite multiple issues including patient harm and broader reputational and stakeholder risks, affecting the high rated score of **Risk 201**, these areas will be disaggregated into separate risks for more accurate scoring and future management. **Risk 542** will be presented utilising the new manage and monitor template at the December 2025 meeting.

22. In private session, Members received assurance on the detail of **Risk 620** and **Risk 260** noting that there were no material changes during this period. A focus on the likelihood score for both risks will be included at the closed FPC in September 2025.

23. The six **risk appetite statements** will be presented at the Board Development Day on 19 September 2025 ahead of Board approval.

24. Members welcomed Dan King, the Trust's **new Risk Manager** who is supporting the enterprise risk management programme and is exploring options for a new electronic risk management system for 2026/27.

COMMITTEE AGENDA FOR MEETING IN JUNE		
Standing Financial Instructions Changes	Internal Audit: - Progress report - MAI Audit - OCP Audit - Amendments to 25/25 plan	Audit Wales Update Report
Risk Management and BAF	Risk Management Policy	2025/26 effectiveness reviews
Integrated Governance Programme	Mid year review of changes to board and committee operating arrangements	Audit tracker
Bi-annual policy report	Assurance to ARAC on Speaking Up Safely Framework	Assurance to ARAC on Near Misses
Losses and special payments		

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

	Attended
	Deputy attended
	Apologies received
	No longer member

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

[2] Jason Killens, CEO, joined for the presentation and endorsement of the annual report and audited accounts

Internal Audit Progress Report

Audit, Risk and Assurance Committee

December 2025

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

Contents

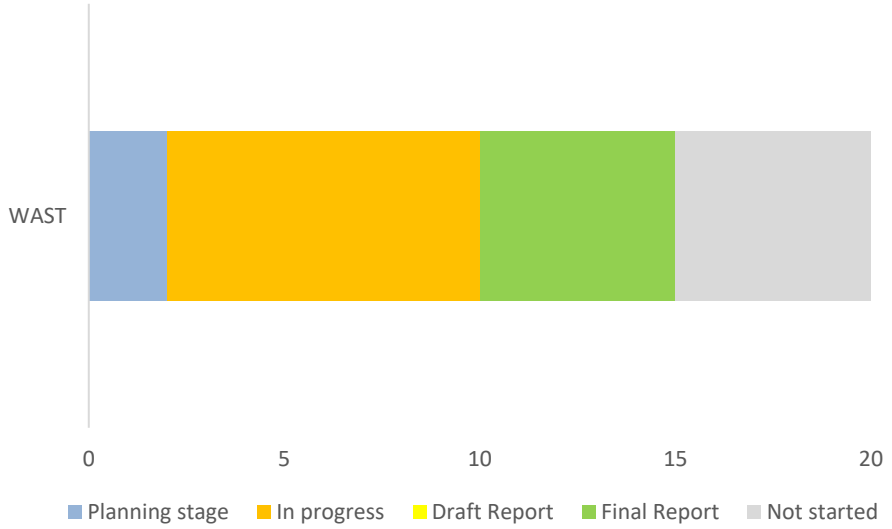
1. Introduction

The purpose of this report is to:

- highlight progress of the 2025/26 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 2025/26 Internal Audit Plan

There are 20 reviews in the 2025/26 Internal Audit Plan, and overall progress is shown below.



Detailed progress in respect of each of the reviews in the 2025/26 Internal Audit Plan is summarised in Appendix A.

3. Proposed changes to approved plan

At the request of management, an audit of the Clinical Prioritisation and Assessment Software (CPAS) Group will be included in the 2025/26 Internal Audit Plan, replacing the previously scheduled review of Remote Clinical Support. This change reflects the significant high-level developments currently underway within CPAS as part of the Clinical Model Transformation. It is proposed that the Remote Clinical Support audit will be deferred to quarter 1 of the 2026/27 Internal Audit programme. This amendment was approved at the September Audit, Risk and Assurance Committee meeting following a paper submitted by the Trust, and is noted here for completeness.

4. Follow Up of Internal Audit Recommendations

As previously communicated and agreed with the Trust, we have introduced a revised approach to follow up for the 2025/26 Internal Audit plan year. A minimum of 50% of high priority findings and 10% of medium priority findings from internal audit

reports issued during 2024/25 will be subject to review throughout the year. Selection will be based on those recorded as closed within the Trust's recommendation tracker.

Our initial review focused on recommendations with an original implementation date on or before 31 March 2025. Of the 97 high and medium priority recommendations issued in 2024/25, 38 (39%) were expected to be closed by this date. Closure had been recorded on the tracker for 26 (68%) of these. Of the 12 remaining open items, nine have revised target dates recorded on the tracker: six in Quarter 1 of 2025/26, two in Quarter 2, and one in Quarter 3. Three items were still pending assignment of target dates.

A sample of six recommendations (three high priority and three medium priority) from four reports was selected for validation (see Table 1 in appendix B). Sufficient evidence was provided to confirm closure for all the recommendations. However, we note that recommendation (1.1) from the Occupational Health & Wellbeing audit had initially been marked as closed on the tracker but was subsequently reopened with a revised closure date of 31 October 2025.

Our next review will be considered in two tranches: (1) recommendations with an expected implementation date on or before 31 May 2025, aligning with the Quarter 1 update provided by the Head of Compliance & Assurance; and (2) those recommendations with an expected implementation date on or before 31 August 2025, aligning with the Quarter 2 update. A further 37 recommendations (including the six at this review with revised target dates) from 2024/25 audits are expected to be closed within this period, from which our next sample will be selected. Our conclusions will be reported at the March 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. Key Performance Indicators

Correct on 31 October 2025

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2025/26	●	March	By 30 June
Audits reported over planned	●	5	7
Work in progress		8	
Report turnaround: time from fieldwork completion to draft reporting [10 days]	●	4 out of 5	80%
Report turnaround: time taken for management response to draft report [15 days]	●	3 out of 3	80%
Report turnaround: time from management response to issue of final report [10 days]	●	3 out of 3	80%

Key:

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

7. Recommendation

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

Appendix A: Progress against 2025/26 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Risk Management and Assurance	Not started			May / June 2026
Welsh Language Standards	In progress			March / April 2026
Follow Up	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.		May / June 2026
Budget Setting	In progress	*The timing of this audit may be subject to change, as it is aligned with related reviews currently being undertaken across NHS Wales.*		March / April 2026
Clinical Equipment	Final report	Reasonable	The Trust has made notable progress in clinical equipment safety and management. Further improvements in inventory tracking, maintenance records, and incident reporting will enhance assurance and operational effectiveness.	December 2025
Clinical Model Transformation Programme Management	In progress			March 2026
Integrated Medium Term Plan (IMTP) Development Process	Final report	Substantial	Strengthening prioritisation tracking, project framework use, and timeline clarity will further enhance IMTP delivery, supporting resilience and adaptability amid organisational change and resource pressures.	December 2025
Cymru High Acuity Response Unit (CHARU)	In progress			March/ April 2026
Remote Clinical Support	*See section 3 – Audit deferred at the request of management. This has been replaced with an audit of the Clinical Prioritisation and Assessment Software (CPAS) Group.*			
Clinical Prioritisation and Assessment Software (CPAS) Group	Not started			March / April 2026

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Manchester Arena Inquiry	Final report	Substantial	The Trust demonstrated strong governance and proactive implementation of Manchester Arena Inquiry recommendations. One issue was noted, not all staff received training via Mandatory In-Service Training (MIST) days due to non-attendance.	September 2025
Capacity Management Plan	Not started			March / April 2026
High Risk Record Policy	Not started			May / June 2026
Data management practices / Devolved data	In progress			March 2026
Emerging technology adoption	Planning			March / April 2026
Business Continuity	In progress			March / April 2026
Organisational Change Policy	Final report	Reasonable	Processes for managing organisational change are developing but require clearer guidance, improved planning, consistent application, better monitoring, and structured learning to support effective delivery and continuous improvement across the Trust.	September 2025
Mandatory In-Service Training (MIST)	Final report	Reasonable	MIST Days achieved strong attendance and compliance rates, supporting staff development. Continued improvements in guidance, oversight, and platform integration will enhance training effectiveness and ensure sustained workforce readiness. Broader CPD hour recording remains an area for improvement.	December 2025
Job Evaluation	Planning			May / June 2026
Ambulance Replacement Programme	Not started			May / June 2026
Fire Safety	In progress			March 2026

[1] May be subject to change

Appendix B: Follow Up of Internal Audit Recommendations

Table 1: Sample of closed recommendations as at 31 March 2025.

Report Title	Recommendation reference & detail		Priority rating	Internal Audit Assessment
Limited Assurance Reports				
Resourcing Policy (November 2024)	2.1	Review of Working Time (WT) Regulations breach analysis reports	**High**	Appropriately classified as closed.
	2.2	Assess training needs for Resource Coordinators or areas where WT breaches occur	**High**	Appropriately classified as closed.
Reasonable Assurance Reports				
Integrated Quality & Performance Management Framework (November 2024)	1.1	Review of the Framework's work programme to incorporate SMART criteria to define success and provider realistic timescales for delivery	**High**	Appropriately classified as closed
	2.1	The Communication Plan's action plan to be revised to include additional actions pertaining to the later phases.	**Medium**	Appropriately classified as closed.
Exposure to Fumes (December 2024)	2.1	A risk assessment work programme should be in place to ensure that all Emergency Departments are risk assessed on a regular basis.	**Medium**	Appropriately classified as closed.
Occupational Health & Wellbeing (March 2025)	1.1	Delivery of Wellbeing Strategy – implementation and measurement plan to be finalised and approved; including key deliverables, how they will be promoted and how effectiveness will be measured.	**Medium**	This recommendation had initially been marked as closed on the tracker but was subsequently reopened with a revised closure date of 31 October 2025.

Mandatory In-Service Training

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust

Reasonable Assurance

Contents

Review Reference	WAS-2526-17
Fieldwork	June - October 2025
Executive Sign Off	19 November 2025
Audit Committee	2 December 2025
Executive Lead	Carl Kneeshaw, Director of People
Audit Team	Osian Lloyd, Head of Internal Audit
	Felicity Quance, Deputy Head of Internal Audit

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

Executive Summary

Purpose

This review evaluates the impact and effectiveness of the new Mandatory In-Service Training (MIST) Days, introduced in 2022/23 to replace the previous Continuing Professional Development (CPD) face-to-face sessions. The focus is on how well these arrangements support compliance with statutory and mandatory training requirements.

Overview

All staff working within the Welsh Ambulance Services University NHS Trust ('the Trust') are required to demonstrate essential knowledge and skills, either mandated by law or required by Welsh Government, NHS Wales, or the Trust itself. This is a key component of their duty of care to themselves, colleagues and patients. A key part of exercising this duty is understanding how to set, maintain and operate in a safe working environment through completion of relevant statutory and mandatory training, which helps mitigate the risk of harm.

Statutory training is legally required, while mandatory training is determined by the Trust based on local needs and priorities, which includes patient safety, Welsh language requirements and information governance. Most training can be completed online, with the exception of specific areas which need to be delivered face-to-face annually or bi-annually. The Trust also utilises annual refresher sessions via MIST Days, which replaced the previous CPD day format for all operational colleagues.

Our review has focused on operational and patient facing roles, specifically evaluating the 15 CPD hours allocated to MIST Day attendance and completion of statutory and mandatory training via ESR. It is noted that broader CPD hours required under contractual obligations are not consistently recorded or monitored. While this limits assurance that staff are consistently engaging in ongoing professional development, it falls outside the scope of this review, and no formal finding has been raised within this report.

Following completion of the 2024/25 MIST programme, attendance reached 90.44%, with overall ESR compliance at 87.84%, both exceeding the minimum Welsh Government Target of 85%. However, it remains difficult to determine whether MIST days have led to improved compliance compared to the previous CPD day's structure, particularly in light of the disruption caused by the Covid-19 pandemic during 2020/21 and 2021/22. Additionally, we note that certain modules and service areas continue to demonstrate persistently low levels of compliance. These areas will require targeted attention and focused improvement efforts going forward.

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

- Updated guidance is not consistently reaching the appropriate staff, leading to gaps in awareness and application.
- Absence of a systematic training needs analysis, resulting in potential misalignment between role expectation and training provision.
- Resource constraints within the Learning & Development Team are impacting progress with the full rollout of Learn 365.
- Weaknesses identified in accountability structures for reporting and addressing individual non-compliance, with no formal arrangements currently in place to manage persistent issues.

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 guidance is in place detailing what is expected of Trust staff in relation to MIST, which has been effectively communicated across the organisation.	1	**Reasonable**
2	Processes to identify and respond to training needs are in place and operating effectively.	2	**Reasonable**
3	Staff complete mandatory training in line with agreed timeframes, and accurate records are maintained.	3	**Reasonable**
4	Staff have access to the appropriate training platforms and resources in order to undertake the mandatory training that has been attributed to their role.	4	**Reasonable**
5	There is regular monitoring and reporting of training compliance throughout the Trust, with effective initiatives in place to improve areas with low compliance levels.	3	**Reasonable**

Management Actions

0 High Priority

4 Medium Priority

Themes

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Public Perception & Reputational Risk

At a Glance: Statutory and Mandatory Training Compliance Rates

The following table sets out the Trust's compliance rate, as at the date of audit fieldwork, for each of the mandatory and statutory training areas (21 in total, split across multiple compliance levels); and the compliance rate recorded for the sample of staff reviewed during the course of fieldwork.

Module	Statutory and Mandatory Training areas	Non compliance (2024/25) for sample reviewed during audit	Whole organisation compliance as at 23/09/25
	Core Skills Training Framework (CSTF): The CSTF is used to standardise the focus and the delivery of key statutory and mandatory training skills across the NHS in Wales.		
1	Equality, Diversity and Human Rights	27%	88%
2	Fire Safety	23%	81%
3	Health, Safety and Welfare	23%	83%
4	Infection Prevention and Control - Level 1	13%	95%
	Infection Prevention and Control - Level 2	37%	85%
5	Information Governance (Wales)	30%	91%
6	Moving and Handling - Level 1	13%	95%
	Moving and Handling - Level 2	57%	97%
7	Resuscitation - Level 1	57%	82%
	Resuscitation - Level 2	69%	84%
	Resuscitation - Level 3	86%	73%
8	Safeguarding Adults - Level 1	17%	95%
	Safeguarding Adults - Level 2	20%	96%
9	Safeguarding Children - Level 1	27%	95%
	Safeguarding Children - Level 2	30%	96%
10	Violence and Aggression (Wales) - Module B	30%	95%
	Violence and Aggression (Wales) - Module C	60%	89%
	Mandatory / Local: These are areas determined locally by the Trust or the wider NHS in Wales, as areas requiring completion which could relate to statutory and regulatory requirements, or areas of concern as highlighted following incidents and trends.		
11	Welsh Language Awareness	53%	76%
12	Dementia Awareness	0%	98%
13	Fraud Awareness	40%	82%
14	Paul Ridd Learning Disability Awareness Training	50%	80%
15	Violence Against Women, Domestic Abuse and Sexual Violence	53%	77%
16	Consent - 3 Years	53%	75%
17	NHS Wales - Anti-racism	73%	66%
18	Prevent Awareness	63%	66%
19	Duty of Quality	33%	84%
20	Duty of Candor	57%	75%
21	Prevent - Referrals	80%	66%

Findings & Agreed Action Plan

Objective 1: Appropriate guidance is in place detailing what is expected of Trust staff in relation to MIST, which has been effectively communicated across the organisation.	**Reasonable**

The Trust's 'Management of Statutory and Mandatory Training and Utilisation of CPD Hours' guidance document for Emergency Medical Services (EMS) and Ambulance Care Service (ACS) colleagues aims to provide clear direction to ensure compliance with the annual Mandatory In-Service Training (MIST) programme and the recording of Continuing Professional Development (CPD) hours. It was last updated in April 2025 and supersedes the 'Utilisation and Management of CPD Hours- Guidance Document' (September 2019). This update was completed in-year as part of the undertaken by the newly established 'MIST Compliance Task & Finish Group'. We were advised that the updated document was also presented to the Senior Operations Team (SOT) for review and subsequently cascaded to the Executive Management Group (EMG), with an action for respective senior and operational managers to share with their local teams.

Additionally, as part of a separate ongoing internal audit review, discussions with five Paramedics revealed that they had not received any verbal or written communication regarding the updated guidance. Furthermore, they were unaware of both the current version and its predecessor (see **Key Finding 1**). However, we note that the updated document was published on Siren towards the end of audit fieldwork (25th September 2025).

As part of the Trust's training arrangements, and to ensure that all operational staff receive appropriate time towards the completion of statutory and mandatory training, full time colleagues are allocated 52 CPD hours per year (contracted for 37.5 hours per week and rostered to work 36.5 hours therefore facilitating the 52 hours). Equivalent arrangements are also in place for part time colleagues, with training expectations considered during shift rostering.

Of the 52 CPD hours, 7.5 hours are allocated for attendance at the annual MIST Day, which incorporates three key areas that require face-to-face training – Resuscitation, Moving and Handling, and Violence and Aggression (Wales). The MIST Day also covers topical areas deemed necessary for inclusion; in recent years, these have included airway management, safety harnesses and seizure management. A further 7.5 hours are allocated for completing outstanding statutory training requirements on ESR. As outlined on page 3, for the 2025/26 MIST Programme there are 21 areas (2024/25: 19 areas) of statutory and mandatory training, split across compliance levels depending on the clinical and operational expectations of individual roles; and including Duty of Candor and Anti-Racism training.

The remaining 37 CPD hours are intended for broader professional development, including activities that help maintain clinical competence and fitness to practise. As stated in the guidance document, *'colleagues are encouraged to continuously develop themselves by accessing relevant CPD opportunities; this could be in the form of a formal training course, reading an article, watching a video, shadowing a colleague or undertaking reflective practice.'*

While the guidance clearly outlines the intended use of these hours, for broader professional development—including maintaining clinical competence and fitness to practise, responsibility ultimately rests with individual staff members to utilise this time appropriately. However, we were unable to establish the Trust's arrangements in capturing and monitoring this activity, either at a local or corporate level, to ensure that time awarded is being effectively used. Furthermore, there was no evidence of mitigating arrangements in place for instances where CPD hours are not fully utilised. This limits the level of assurance that staff are consistently engaging in ongoing development beyond the statutory and mandatory requirements. As this area falls outside the scope of this audit, which focused specifically on the Mandatory In-Service Training (MIST) programme, we have not raised this as a formal finding. Nonetheless, we considered it important to highlight within the report, given its relevance to broader staff development and assurance over CPD utilisation.

Key Findings		Risk & Impact	Agreed Management Action
1	**Trust Wide Communication of Updated Guidance** Upon update of the 'Management of Statutory and Mandatory Training and Utilisation of CPD Hours' guidance (May 2025), there was the expectation that operational managers share with staff. However, during discussions with members of staff, it was noted that they had not received any communication in relation to the document and were unaware of its existence. Further, despite the May issue date, it wasn't made available on Siren until later in the year – appearing under policies in September 2025 and in a news bulletin in October 2025.	Insufficient communication of updated guidance increases the risk of inconsistent training practices and underutilisation of CPD hours, potentially affecting compliance, staff development, and service quality.	**Agreed Action:** • Ensure that updated policies and guidance documents are promptly and clearly communicated to all relevant staff, through established channels at the time of release. • Introduce periodic checks or feedback mechanisms to assess staff awareness of newly issued guidance, especially where compliance is impacted. **Expected Evidence of Implementation:** • Updated guidance shared through planned communication channels (emails, meetings, bulletins) and documented in communication plans. • Evidence that staff have received, understood and acknowledged the guidance, supported by meeting records, feedback, logs etc.
		Medium Priority	**Officer:** Jo Kelso, Head of Workforce Education & Development **Target Implementation Date:** 31 May 2026
	Theme: Communication & Engagement	Control Operation	

Objective 2: Processes to identify and respond to training needs are in place and operating effectively.	**Reasonable**

Statutory and mandatory training requirements across the Trust are aligned with both local and national standards, including those set out under the Core Skills Training Framework (CSTF). All Trust staff are required to maintain competency across 21 areas, with the required competency level determined by the scope of practice per individual role. For example, Paramedics and above require Level 3 Resuscitation, whereas Technicians and other patient-facing staff below this level are expected to complete Level 2 Resuscitation.

We note, that outside of the 21 topics included in the MIST programme, there are currently no additional training areas that require refreshing on a mandatory cyclical basis, to enable staff to remain competent in their roles. We were advised that patient-facing roles are considered to be undertaking the wider scope of their practice throughout their day-to-day activities and therefore maintaining a 'refresh' of those broader clinical skills on a regular basis. However, as highlighted under objective 1, the Trust does not currently capture or record operational and clinical skill activity for these staff groups. As a result, there is no formal assurance that staff are exposed to the full range of skills required within their scope of practice.

A sample of 30 members across both EMS and ACS was reviewed to assess whether the Trust and wider NHS Wales training requirements recorded in ESR were appropriately aligned with the expectations of their roles. During this review, it was identified, through discussions with the Trust's ESR colleagues, that the Ambulance Care Assistant 1 role does not include Resuscitation level 2 as a minimum requirement, despite the expectation that any patient facing role should meet at least this level. While this was the only exception noted, it highlights a broader issue that the Trust does not currently conduct periodic reviews of role profiles to ensure they remain aligned with the minimum competency requirements relevant to each role's scope of practice. **(See Key Finding 2)**

Key Findings		Risk & Impact	Agreed Management Action
2	**Organisational Oversight of Training Needs Analysis** The Trust's statutory and mandatory training aligns with the minimum standard required across all other NHS Wales bodies, with compliance recorded via ESR (and through attendance at the MIST days). However, in terms of reviewing/monitoring skill activity for patient facing members of staff, there is currently no organisational oversight to ensure all roles are appropriately aligned with the minimum competency requirements to their scope of practice. As a result, there is limited assurance that all roles are appropriately matched to the minimum competency requirements, which may impact the effectiveness of training provision and workforce capability.	Lack of oversight of training needs analysis may result in misalignment between staff roles and required competencies, reducing training effectiveness and potentially impacting service quality and patient safety.	**Agreed Action:** • Develop a formal framework to review and monitor operational and clinical skill activity for patient-facing staff to ensure alignment with role-specific competency requirements. • Conduct a comprehensive mapping exercise to ensure all patient-facing roles are appropriately matched to the minimum competency standards required for safe and effective practice. • Introduce regular audits or reporting mechanisms, to an appropriate forum, to provide assurance that staff competencies are being maintained and developed in line with organisational expectations.
			Expected Evidence of Implementation: • Documented framework outlining how clinical and operational skills are monitored. • Completed mapping exercise showing alignment of patient-facing roles to competency standards (covering the CSTF & WG mandated topics) and records of actions taken in response to identified gaps or risks. • ESR and local reports showing compliance trends, intervention tracking and updates to competency requirements if applicable.
		Medium Priority	**Officer:** Jo Kelso, Head of Workforce Education & Development **Target Implementation Date:** 31 August 2026
	Theme: Training & Development	Control Design	

Objective 3: Staff complete mandatory training in line with agreed timeframes, and accurate records are maintained.	**Reasonable**

The Metrics report presented to People and Culture Committee in May 2025 (covering data up to the end of March 2025), noted that the in-year MIST Day attendance was 90.44%, with overall ESR compliance at 87.84%, both exceeding the minimum Welsh Government Target of 85%.

As noted within objective 2, we were provided with a listing of staff competency across all operational roles, including those members of staff that were required to attend the MIST Day in year (circa 2,500) and their overall ESR training compliance. From this data, we identified that 309 members of staff had not attended the MIST Day in 2024/25, and were therefore operationally, clinically and administratively non-compliant with the Trust's minimum training expectations.

To explore this further, a sample of 30 staff members was selected across EMS and ACS. Discussions were held between a Learning and Development Manager and the relevant line managers to gather insights into the reasons for staff non-attendance at MIST, in addition to understanding their overall ESR compliance status. A summary of the key findings from this sample is set out below (with full testing details included at Appendix A):

- 23 of the 30 had no justifiable reason for not attending the 2024/25 MIST Day.
- All 30 had missed two or more MIST Days since the inception of the programme in 2022/23.
- ESR compliance rates (for those listed on page 3) were: 12 having completed up to 60% of the required modules; 15 having completed between 61% and 85%; and 3 having completed between 86% and 100%. The most outdated training record dated back to 2016.
- The areas with the lowest compliance across the sample include Prevent Awareness, Prevent Referrals, Violence and Aggression Module C and Resuscitation Levels 2 and 3, as set out on page 3 of this report.

Whilst the responsibility for maintaining statutory and mandatory training, as well as completing CPD requirements, rests with individual staff members, there appear to be weaknesses in how persistent non-compliance is identified and addressed. This highlights the need to strengthen oversight mechanisms and improve the uptake of training across the workforce (See **Key Finding 3**).

Key Findings		Risk & Impact	Agreed Management Action
3	**Lack of Formal Process to Address Training Non-Compliance** Our review of MIST Day attendance monitoring arrangements identified that no formal processes are currently in place to address persistent non-compliance. This was evidenced through our sample testing, where all 30 staff members had failed to attend a MIST Day for two consecutive years or more, since the programme's inception in 2022/23. Despite this repeated non-attendance, there was limited evidence of structured follow-up or escalation, and no defined accountability framework to support or justify non-compliance. This gap in process and oversight presents a risk to maintaining minimum competency standards across operational roles. The same is applicable to ESR module completion – despite reporting provided locally in respect of non-compliance, there is minimal evidence of intervention by respective line managers to address.	Without a formal process to address training non-compliance, there is a risk that staff may not meet required competency standards, potentially compromising service delivery, workforce readiness, and patient safety.	**Agreed Action:** • Develop and enforce a structured process to address persistent non-attendance at MIST days, including defined escalation steps, accountability measures and reporting to an appropriate forum. • Establish clear roles and responsibilities for monitoring and responding to training non-compliance ensuring line managers are actively engaged in follow up and resolution. • Enhance the use of ESR and local reporting tools to track compliance trends and trigger timely interventions for staff who repeatedly fail to meet training requirements. **Expected Evidence of Implementation:** • Documented process for managing MIST Day non-attendance, outlining escalation steps, accountability measures and reporting requirements; signed off by senior management. • Governance document detailing line managers' responsibilities for follow up and resolution • A compliance dashboard/reported generated from ESR or local system, showing trend analysis and intervention actions for repeat non-compliance.
		Medium Priority	**Officer:** Jo Kelso, Head of Workforce Education & Development; Jonathan Sweet, Head of Service Operational Delivery Unit; Gemma Robinson, Workforce Systems Manager **Target Implementation Date:** 31 December 2026
	Theme: Performance Monitoring	Control Operation	

Objective 4: Staff have access to the appropriate training platforms and resources in order to undertake the mandatory training that has been attributed to their role.	**Reasonable**

All EMS, and some ACS staff, have been allocated iPads, which are utilised during shifts to support the undertaking of daily operational tasks, and provide access to ESR, enabling completion of statutory and mandatory e-learning modules. For staff who have not been issued an iPad, access to laptops or desktop computers is available at their designated stations.

However, we were advised that the functionality and user experience of ESR on iPads is limited, making it less practical and efficient compared to using a laptop or desktop. In order to overcome this, the Trust have developed the 'Learn 365' (L365) application within Microsoft Teams, to provide employees with a more tailored and accessible platform to complete their e-learning. L365 allows users to access learning content and pathways directly through the Microsoft Teams interface, on both desktop and mobile devices. Not all e-learning packages have been migrated to L365 due to resource constraints within the Learning and Development Team, and, at the completion of audit fieldwork, an expected completion date had not been determined (**see Key Finding 4**).

In recognition of the operational pressures faced by staff, the Trust has also implemented MIST Days as a key mechanism for delivering mandatory training. These sessions provide protected time for staff to complete essential face-to-face modules—such as Resuscitation, Moving and Handling, and Violence and Aggression—which may otherwise be difficult to complete during routine shifts. However, several training sessions are cancelled each year due to low attendance, often caused by staff booking-on but failing to attend. This issue has been escalated to the Quality Management Group (see objective 5)

As referenced in objective 1, operational staff are allocated 37 CPD hours annually to support broader professional development, including learning new skills or enhancing existing ones. While guidance and associated application forms are available to support access to CPD opportunities, there is no central repository or system in place to monitor how this time is utilised. As a result, there is limited assurance that CPD time is being used appropriately, and no mechanism to enforce compliance with expectations for unused CPD hours i.e. financial reimbursement or additional shift work.

Key Findings		Risk & Impact	Agreed Management Action
4	**Limitations in Remote Access and Integration of E-Learning Platforms** The Trust identified limitations in accessing ESR e-learning packages via iPads issued to a significant proportion of the operational workforce. To address this, the Learn365 app, accessible through the Microsoft Teams platform, has been adopted to improve access to e-learning content. Although all relevant staff now have access to the Learn 365 platform, not all statutory and mandatory training modules are currently available on the platform. As a result, staff must continue to use both Learn365 and ESR to maintain full compliance. We were advised that the delay in transitioning fully to L365 is primarily due to resource constraints within the Learning and Development Team and the need to update training content. In addition, while compliance reports can be generated from L365, the lack of data integration with ESR means that updates must be manually entered into ESR three times a week – a process described as time consuming and inefficient.	Limited access and integration between Learn365 and ESR may lead to inconsistent training compliance data, increased administrative burden, and delays in ensuring staff meet statutory and mandatory training requirements—potentially affecting workforce readiness and assurance reporting.	**Agreed Action:** • Provide clear guidance to staff on how to navigate both platforms, including which modules are available on each system. • Review the scope of the future workforce system which will include a L&D module/platform and engage in the new system development, so it is fit for purpose and easily accessible on iPads and mobile devices. • Explore options for automating data transfer between Learn365 and ESR to eliminate manual updates, reduce administrative burden and improve data accuracy. • Develop regular communications to managers and teams on the need to complete training in a timely way. • Produce reports for sharing with managers on training completions and escalate to senior managers where necessary. **Expected Evidence of Implementation:** • Communications issued to staff regarding platform use and compliance. • Evidence of workforce system review showing engagement in system design discussions and accessibility requirements for mobile devices. • Technical feasibility report outlining integration options and automation proposals vs manual data entry frequency and associated resource impact. • Copies of communications sent to managers and staff reminding them of training deadlines. • As per KF3, a compliance dashboard/reported generated from ESR or local system, showing trend analysis and intervention actions for repeat non-compliance.
		Medium Priority	**Officer:** Jo Kelso, Head of Workforce Education & Development; Gemma Robinson, Workforce Systems Manager **Target Implementation Date:** 31 December 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 5: There is regular monitoring and reporting of training compliance throughout the Trust, with effective initiatives in place to improve areas with low compliance levels.	**Reasonable**

The reporting framework includes the following components:

- MIST Compliance Task and Finish Group (MCTFG): Established in early 2025, the group aims to identify barriers to staff completing MIST and explore ways to improve annual compliance across all staff grades. Meetings are held as needed, with outputs tracked via an action log rather than formal minutes. Each action lists an owner, review date and completion date. We note that the terms of reference do not specify a reporting route.
- The Quality Management Group (QMG) is a weekly advisory body focused on patient safety and clinical improvement and its oversight spans four key service areas: EMS, EMSC, EPRR & Volunteers; Integrated Care; Ambulance Care; Resourcing & Corporate Services. Its functions include, advising on quality-related decisions; reviewing Learning from Events reports; approving content for the Quality Newsletter; monitoring arrangements related to quality improvement, communication, and training compliance. The Learning Development provide a training compliance update at each weekly meeting.
- Senior Operations Team (SOT): whilst not defined as a formal reporting route within the MCTFG terms of reference, we were advised that any matters requiring escalation are taken to the SOT. We reviewed the minutes from the two meetings where MIST compliance was most recently discussed (in November 2024 and May 2025), and there is also evidence to support some reporting from the MCTFG. Additionally, MIST compliance is reported to the Senior Leadership Team (SLT) via fortnightly AAA (Alert, Advise, Assure) reports, which provide updates on upcoming sessions, the number of places booked, and session availability.
- People & Culture Committee: The People & Culture Metrics Scorecard includes cumulative rates of attendance at MIST days and wider training compliance. Similar data is presented within the Monthly Integrated Quality and Performance Report (MIQPR), which is shared with all Board-level Committees and Trust Board.

The most recent MIQPR indicated reported a combined Statutory & Mandatory Training compliance rate of 88.98% as at July 2025, exceeding the Welsh Government target of 85% for the eighth consecutive month. Several individual areas also met or exceeded the target, including Dementia Awareness (98.50%), Moving & Handling (95.93%) and Safeguarding Adults (95.61%). However, the following areas remain consistently below target:

- Fire Safety 80.97% (renewal every 2 years)
- Paul Ridd 79.27% (Introduced Feb 2023; no requirement to renew)
- Fraud Awareness 80.91% (Introduced Aug 2023; renewal every 3 years)
- Violence Against Women, Domestic Abuse & Sexual Violence 76.42% (Introduced Jan 2017; renewal every 3 years)
- Welsh Language Awareness 74.67% (Introduced Apr 2023; renewal every 3 years)

In respect of local reporting arrangements, the Operations Business Manager advised that fortnightly emails are issued by the Business Support Officers to localities, providing updated MIST compliance rates. While training and compliance are reportedly discussed during local informal catch-ups, there is no defined process to report back on actions taken. (**see Key Finding 3**)

Towards the end of the training year, the Learning and Development team issues emails to localities and regions identifying employees who have not attended their MIST Day. However, there is minimal evidence of remedial action being taken to address repeated non-attendance or where ESR compliance is below target. The only notable exception was the recent improvement in Information Governance training compliance, which was achieved following Board-level intervention, due to potential implications involving the ICO (see objective 3 and **Key Finding 3**).

Appendix A: Summary of Sample Testing

IA Ref	Role	ESR Compliance August 25	Non-compliance dates back to	Attendance at MIST Day			Mitigating reason for non-attendance at MIST day
				22/23	23/24	24/25	
1	Emergency Ambulance Practitioner	88.90%	17/03/2024	✗	✗	✓ - attended as part of Parmaedic induction in year	Attended under induction to new role but persistent non-attendance in previous years
2	Paramedic Band 6	73.30%	01/01/2017	✗	✗	✗	No Mitigating Factors
3	Duty Operations Manager	42.90%	19/10/2019	✗	✗	✗	No Mitigating Factors
4	Paramedic Band 6	73.30%	09/02/2023	✗	✗	✗	No Mitigating Factors
5	Emergency Ambulance Practitioner	75.60%	16/02/2023	✗	✗	✗	No Mitigating Factors
6	Emergency Ambulance Practitioner	34.10%	19/11/2022	✗	✗	✗	No Mitigating Factors
7	Community First Responder Trainer	50.00%	18/10/2016	✗	✗	✗	No Mitigating Factors
8	Paramedic Band 6	71.10%	01/01/2017	✓	✗	✗	No Mitigating Factors
9	Paramedic Band 6	66.70%	10/08/2022	✗	✗	✗	No Mitigating Factors
10	Emergency Ambulance Practitioner	73.20%	01/01/2017	✓	✗	✗	No Mitigating Factors
11	Ambulance Care Assistant 2 (ACA2)	73.20%	01/01/2017	✗	✗	✗	No Mitigating Factors
12	Ambulance Care Assistant 2 (ACA2)	66.70%	14/07/2022	✗	✗	✓ - attended as part of EMT induction in year	Attended under induction to new role but persistent non-attendance in previous years
13	Paramedic Band 6	68.90%	17/02/2023	✗	✗	✗	No Mitigating Factors
14	Paramedic Band 6	75.60%	10/02/2023	✗	✗	✗	No Mitigating Factors
15	Paramedic Band 6	60.00%	15/09/2024	✓	✗	✗	No Mitigating Factors
16	Paramedic Band 6	56.50%	08/05/2024	✓	✗	✗	No Mitigating Factors
17	Emergency Ambulance Practitioner	58.50%	07/03/2021	✗	✗	✗	No Mitigating Factors
18	Paramedic Band 6	68.90%	20/09/2023	✓	✗	✗	No Mitigating Factors
19	Emergency Medical Technician	24.40%	15/10/2023	✓	✗	✗	Career Break
20	Paramedic Band 6	55.60%	08/07/2023	✓	✗	✗	Maternity leave and alternative duties support 24/25 non-attendance
21	Paramedic Band 6	51.10%	13/06/2022	✗	✗	✗	Maternity leave and alternative duties support 24/25 non-attendance
22	Paramedic Band 6	35.60%	15/03/2023	✗	✗	✗	No Mitigating Factors
23	Emergency Medical Technician	46.30%	19/01/2024	✗	✗	✗	Maternity leave and alternative duties support 24/25 non-attendance
24	Ambulance Care Assistant - B2 (NEPTS)	50.00%	12/09/2020	✗	✗	✗	No Mitigating Factors
25	Ambulance Care Assistant (NEPTS)	100.00%	N/A	✗	✗	✗	No Mitigating Factors
26	Ambulance Care Assistant (NEPTS)	17.24%	26/10/2017	✗	✗	✗	No Mitigating Factors - Left Organisation in June '25
27	Ambulance Care Assistant 2 (ACA2)	87.80%	31/12/2023	✗	✗	✓ - attended as part of EMT induction in year	Attended under induction to new role but persistent non-attendance in previous years
28	Ambulance Care Operational Team Leader	80.60%	10/08/2023	✗	✗	✗	No Mitigating Factors
29	Senior APP	68.90%	10/10/2021	✗	✗	✗	No Mitigating Factors
30	Operations Assistant, Community Support	67.50%	06/08/2021	✗	✗	✗	No Mitigating Factors

**This represents the date on which compliance for a particular training module expired, indicating that it has been non-compliant since that point*

Appendix B: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Prioritisation of Findings

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

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

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

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

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Shared Services Partnership
Audit and Assurance Services

Mandatory In-Service Training

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust

Reasonable Assurance

Contents

Review Reference	WAS-2526-17
Fieldwork	June - October 2025
Executive Sign Off	19 November 2025
Audit Committee	2 December 2025
Executive Lead	Carl Kneeshaw, Director of People
Audit Team	Osian Lloyd, Head of Internal Audit
	Felicity Quance, Deputy Head of Internal Audit

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

This review evaluates the impact and effectiveness of the new Mandatory In-Service Training (MIST) Days, introduced in 2022/23 to replace the previous Continuing Professional Development (CPD) face-to-face sessions. The focus is on how well these arrangements support compliance with statutory and mandatory training requirements.

Overview

All staff working within the Welsh Ambulance Services University NHS Trust ('the Trust') are required to demonstrate essential knowledge and skills, either mandated by law or required by Welsh Government, NHS Wales, or the Trust itself. This is a key component of their duty of care to themselves, colleagues and patients. A key part of exercising this duty is understanding how to set, maintain and operate in a safe working environment through completion of relevant statutory and mandatory training, which helps mitigate the risk of harm.

Statutory training is legally required, while mandatory training is determined by the Trust based on local needs and priorities, which includes patient safety, Welsh language requirements and information governance. Most training can be completed online, with the exception of specific areas which need to be delivered face-to-face annually or bi-annually. The Trust also utilises annual refresher sessions via MIST Days, which replaced the previous CPD day format for all operational colleagues.

Our review has focused on operational and patient facing roles, specifically evaluating the 15 CPD hours allocated to MIST Day attendance and completion of statutory and mandatory training via ESR. It is noted that broader CPD hours required under contractual obligations are not consistently recorded or monitored. While this limits assurance that staff are consistently engaging in ongoing professional development, it falls outside the scope of this review, and no formal finding has been raised within this report.

Following completion of the 2024/25 MIST programme, attendance reached 90.44%, with overall ESR compliance at 87.84%, both exceeding the minimum Welsh Government Target of 85%. However, it remains difficult to determine whether MIST days have led to improved compliance compared to the previous CPD day's structure, particularly in light of the disruption caused by the Covid-19 pandemic during 2020/21 and 2021/22. Additionally, we note that certain modules and service areas continue to demonstrate persistently low levels of compliance. These areas will require targeted attention and focused improvement efforts going forward.

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

- Updated guidance is not consistently reaching the appropriate staff, leading to gaps in awareness and application.
- Absence of a systematic training needs analysis, resulting in potential misalignment between role expectation and training provision.
- Resource constraints within the Learning & Development Team are impacting progress with the full rollout of Learn 365.
- Weaknesses identified in accountability structures for reporting and addressing individual non-compliance, with no formal arrangements currently in place to manage persistent issues.

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 guidance is in place detailing what is expected of Trust staff in relation to MIST, which has been effectively communicated across the organisation.	1	**Reasonable**
2	Processes to identify and respond to training needs are in place and operating effectively.	2	**Reasonable**
3	Staff complete mandatory training in line with agreed timeframes, and accurate records are maintained.	3	**Reasonable**
4	Staff have access to the appropriate training platforms and resources in order to undertake the mandatory training that has been attributed to their role.	4	**Reasonable**
5	There is regular monitoring and reporting of training compliance throughout the Trust, with effective initiatives in place to improve areas with low compliance levels.	3	**Reasonable**

Management Actions

0 High Priority

4 Medium Priority

Themes

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Public Perception & Reputational Risk

At a Glance: Statutory and Mandatory Training Compliance Rates

The following table sets out the Trust's compliance rate, as at the date of audit fieldwork, for each of the mandatory and statutory training areas (21 in total, split across multiple compliance levels); and the compliance rate recorded for the sample of staff reviewed during the course of fieldwork.

Module	Statutory and Mandatory Training areas	Non compliance (2024/25) for sample reviewed during audit	Whole organisation compliance as at 23/09/25
	Core Skills Training Framework (CSTF): The CSTF is used to standardise the focus and the delivery of key statutory and mandatory training skills across the NHS in Wales.		
1	Equality, Diversity and Human Rights	27%	88%
2	Fire Safety	23%	81%
3	Health, Safety and Welfare	23%	83%
4	Infection Prevention and Control - Level 1	13%	95%
	Infection Prevention and Control - Level 2	37%	85%
5	Information Governance (Wales)	30%	91%
6	Moving and Handling - Level 1	13%	95%
	Moving and Handling - Level 2	57%	97%
7	Resuscitation - Level 1	57%	82%
	Resuscitation - Level 2	69%	84%
	Resuscitation - Level 3	86%	73%
8	Safeguarding Adults - Level 1	17%	95%
	Safeguarding Adults - Level 2	20%	96%
9	Safeguarding Children - Level 1	27%	95%
	Safeguarding Children - Level 2	30%	96%
10	Violence and Aggression (Wales) - Module B	30%	95%
	Violence and Aggression (Wales) - Module C	60%	89%
	Mandatory / Local: These are areas determined locally by the Trust or the wider NHS in Wales, as areas requiring completion which could relate to statutory and regulatory requirements, or areas of concern as highlighted following incidents and trends.		
11	Welsh Language Awareness	53%	76%
12	Dementia Awareness	0%	98%
13	Fraud Awareness	40%	82%
14	Paul Ridd Learning Disability Awareness Training	50%	80%
15	Violence Against Women, Domestic Abuse and Sexual Violence	53%	77%
16	Consent - 3 Years	53%	75%
17	NHS Wales - Anti-racism	73%	66%
18	Prevent Awareness	63%	66%
19	Duty of Quality	33%	84%
20	Duty of Candor	57%	75%
21	Prevent - Referrals	80%	66%

Findings & Agreed Action Plan

Objective 1: Appropriate guidance is in place detailing what is expected of Trust staff in relation to MIST, which has been effectively communicated across the organisation.	**Reasonable**

The Trust's 'Management of Statutory and Mandatory Training and Utilisation of CPD Hours' guidance document for Emergency Medical Services (EMS) and Ambulance Care Service (ACS) colleagues aims to provide clear direction to ensure compliance with the annual Mandatory In-Service Training (MIST) programme and the recording of Continuing Professional Development (CPD) hours. It was last updated in April 2025 and supersedes the 'Utilisation and Management of CPD Hours- Guidance Document' (September 2019). This update was completed in-year as part of the undertaken by the newly established 'MIST Compliance Task & Finish Group'. We were advised that the updated document was also presented to the Senior Operations Team (SOT) for review and subsequently cascaded to the Executive Management Group (EMG), with an action for respective senior and operational managers to share with their local teams.

Additionally, as part of a separate ongoing internal audit review, discussions with five Paramedics revealed that they had not received any verbal or written communication regarding the updated guidance. Furthermore, they were unaware of both the current version and its predecessor (see **Key Finding 1**). However, we note that the updated document was published on Siren towards the end of audit fieldwork (25th September 2025).

As part of the Trust's training arrangements, and to ensure that all operational staff receive appropriate time towards the completion of statutory and mandatory training, full time colleagues are allocated 52 CPD hours per year (contracted for 37.5 hours per week and rostered to work 36.5 hours therefore facilitating the 52 hours). Equivalent arrangements are also in place for part time colleagues, with training expectations considered during shift rostering.

Of the 52 CPD hours, 7.5 hours are allocated for attendance at the annual MIST Day, which incorporates three key areas that require face-to-face training – Resuscitation, Moving and Handling, and Violence and Aggression (Wales). The MIST Day also covers topical areas deemed necessary for inclusion; in recent years, these have included airway management, safety harnesses and seizure management. A further 7.5 hours are allocated for completing outstanding statutory training requirements on ESR. As outlined on page 3, for the 2025/26 MIST Programme there are 21 areas (2024/25: 19 areas) of statutory and mandatory training, split across compliance levels depending on the clinical and operational expectations of individual roles; and including Duty of Candor and Anti-Racism training.

The remaining 37 CPD hours are intended for broader professional development, including activities that help maintain clinical competence and fitness to practise. As stated in the guidance document, *'colleagues are encouraged to continuously develop themselves by accessing relevant CPD opportunities; this could be in the form of a formal training course, reading an article, watching a video, shadowing a colleague or undertaking reflective practice.'*

While the guidance clearly outlines the intended use of these hours, for broader professional development—including maintaining clinical competence and fitness to practise, responsibility ultimately rests with individual staff members to utilise this time appropriately. However, we were unable to establish the Trust's arrangements in capturing and monitoring this activity, either at a local or corporate level, to ensure that time awarded is being effectively used. Furthermore, there was no evidence of mitigating arrangements in place for instances where CPD hours are not fully utilised. This limits the level of assurance that staff are consistently engaging in ongoing development beyond the statutory and mandatory requirements. As this area falls outside the scope of this audit, which focused specifically on the Mandatory In-Service Training (MIST) programme, we have not raised this as a formal finding. Nonetheless, we considered it important to highlight within the report, given its relevance to broader staff development and assurance over CPD utilisation.

Key Findings		Risk & Impact	Agreed Management Action
1	**Trust Wide Communication of Updated Guidance** Upon update of the 'Management of Statutory and Mandatory Training and Utilisation of CPD Hours' guidance (May 2025), there was the expectation that operational managers share with staff. However, during discussions with members of staff, it was noted that they had not received any communication in relation to the document and were unaware of its existence. Further, despite the May issue date, it wasn't made available on Siren until later in the year – appearing under policies in September 2025 and in a news bulletin in October 2025.	Insufficient communication of updated guidance increases the risk of inconsistent training practices and underutilisation of CPD hours, potentially affecting compliance, staff development, and service quality.	**Agreed Action:** • Ensure that updated policies and guidance documents are promptly and clearly communicated to all relevant staff, through established channels at the time of release. • Introduce periodic checks or feedback mechanisms to assess staff awareness of newly issued guidance, especially where compliance is impacted. **Expected Evidence of Implementation:** • Updated guidance shared through planned communication channels (emails, meetings, bulletins) and documented in communication plans. • Evidence that staff have received, understood and acknowledged the guidance, supported by meeting records, feedback, logs etc.
		Medium Priority	**Officer:** Jo Kelso, Head of Workforce Education & Development **Target Implementation Date:** 31 May 2026
	Theme: Communication & Engagement	Control Operation	

Objective 2: Processes to identify and respond to training needs are in place and operating effectively.	**Reasonable**

Statutory and mandatory training requirements across the Trust are aligned with both local and national standards, including those set out under the Core Skills Training Framework (CSTF). All Trust staff are required to maintain competency across 21 areas, with the required competency level determined by the scope of practice per individual role. For example, Paramedics and above require Level 3 Resuscitation, whereas Technicians and other patient-facing staff below this level are expected to complete Level 2 Resuscitation.

We note, that outside of the 21 topics included in the MIST programme, there are currently no additional training areas that require refreshing on a mandatory cyclical basis, to enable staff to remain competent in their roles. We were advised that patient-facing roles are considered to be undertaking the wider scope of their practice throughout their day-to-day activities and therefore maintaining a 'refresh' of those broader clinical skills on a regular basis. However, as highlighted under objective 1, the Trust does not currently capture or record operational and clinical skill activity for these staff groups. As a result, there is no formal assurance that staff are exposed to the full range of skills required within their scope of practice.

A sample of 30 members across both EMS and ACS was reviewed to assess whether the Trust and wider NHS Wales training requirements recorded in ESR were appropriately aligned with the expectations of their roles. During this review, it was identified, through discussions with the Trust's ESR colleagues, that the Ambulance Care Assistant 1 role does not include Resuscitation level 2 as a minimum requirement, despite the expectation that any patient facing role should meet at least this level. While this was the only exception noted, it highlights a broader issue that the Trust does not currently conduct periodic reviews of role profiles to ensure they remain aligned with the minimum competency requirements relevant to each role's scope of practice. **(See Key Finding 2)**

Key Findings		Risk & Impact	Agreed Management Action
2	**Organisational Oversight of Training Needs Analysis** The Trust's statutory and mandatory training aligns with the minimum standard required across all other NHS Wales bodies, with compliance recorded via ESR (and through attendance at the MIST days). However, in terms of reviewing/monitoring skill activity for patient facing members of staff, there is currently no organisational oversight to ensure all roles are appropriately aligned with the minimum competency requirements to their scope of practice. As a result, there is limited assurance that all roles are appropriately matched to the minimum competency requirements, which may impact the effectiveness of training provision and workforce capability.	Lack of oversight of training needs analysis may result in misalignment between staff roles and required competencies, reducing training effectiveness and potentially impacting service quality and patient safety.	**Agreed Action:** • Develop a formal framework to review and monitor operational and clinical skill activity for patient-facing staff to ensure alignment with role-specific competency requirements. • Conduct a comprehensive mapping exercise to ensure all patient-facing roles are appropriately matched to the minimum competency standards required for safe and effective practice. • Introduce regular audits or reporting mechanisms, to an appropriate forum, to provide assurance that staff competencies are being maintained and developed in line with organisational expectations.
			Expected Evidence of Implementation: • Documented framework outlining how clinical and operational skills are monitored. • Completed mapping exercise showing alignment of patient-facing roles to competency standards (covering the CSTF & WG mandated topics) and records of actions taken in response to identified gaps or risks. • ESR and local reports showing compliance trends, intervention tracking and updates to competency requirements if applicable.
		Medium Priority	**Officer:** Jo Kelso, Head of Workforce Education & Development **Target Implementation Date:** 31 August 2026
	Theme: Training & Development	Control Design	

Objective 3: Staff complete mandatory training in line with agreed timeframes, and accurate records are maintained.	**Reasonable**

The Metrics report presented to People and Culture Committee in May 2025 (covering data up to the end of March 2025), noted that the in-year MIST Day attendance was 90.44%, with overall ESR compliance at 87.84%, both exceeding the minimum Welsh Government Target of 85%.

As noted within objective 2, we were provided with a listing of staff competency across all operational roles, including those members of staff that were required to attend the MIST Day in year (circa 2,500) and their overall ESR training compliance. From this data, we identified that 309 members of staff had not attended the MIST Day in 2024/25, and were therefore operationally, clinically and administratively non-compliant with the Trust's minimum training expectations.

To explore this further, a sample of 30 staff members was selected across EMS and ACS. Discussions were held between a Learning and Development Manager and the relevant line managers to gather insights into the reasons for staff non-attendance at MIST, in addition to understanding their overall ESR compliance status. A summary of the key findings from this sample is set out below (with full testing details included at Appendix A):

- 23 of the 30 had no justifiable reason for not attending the 2024/25 MIST Day.
- All 30 had missed two or more MIST Days since the inception of the programme in 2022/23.
- ESR compliance rates (for those listed on page 3) were: 12 having completed up to 60% of the required modules; 15 having completed between 61% and 85%; and 3 having completed between 86% and 100%. The most outdated training record dated back to 2016.
- The areas with the lowest compliance across the sample include Prevent Awareness, Prevent Referrals, Violence and Aggression Module C and Resuscitation Levels 2 and 3, as set out on page 3 of this report.

Whilst the responsibility for maintaining statutory and mandatory training, as well as completing CPD requirements, rests with individual staff members, there appear to be weaknesses in how persistent non-compliance is identified and addressed. This highlights the need to strengthen oversight mechanisms and improve the uptake of training across the workforce (See **Key Finding 3**).

Key Findings		Risk & Impact	Agreed Management Action
3	**Lack of Formal Process to Address Training Non-Compliance** Our review of MIST Day attendance monitoring arrangements identified that no formal processes are currently in place to address persistent non-compliance. This was evidenced through our sample testing, where all 30 staff members had failed to attend a MIST Day for two consecutive years or more, since the programme's inception in 2022/23. Despite this repeated non-attendance, there was limited evidence of structured follow-up or escalation, and no defined accountability framework to support or justify non-compliance. This gap in process and oversight presents a risk to maintaining minimum competency standards across operational roles. The same is applicable to ESR module completion – despite reporting provided locally in respect of non-compliance, there is minimal evidence of intervention by respective line managers to address.	Without a formal process to address training non-compliance, there is a risk that staff may not meet required competency standards, potentially compromising service delivery, workforce readiness, and patient safety.	**Agreed Action:** • Develop and enforce a structured process to address persistent non-attendance at MIST days, including defined escalation steps, accountability measures and reporting to an appropriate forum. • Establish clear roles and responsibilities for monitoring and responding to training non-compliance ensuring line managers are actively engaged in follow up and resolution. • Enhance the use of ESR and local reporting tools to track compliance trends and trigger timely interventions for staff who repeatedly fail to meet training requirements. **Expected Evidence of Implementation:** • Documented process for managing MIST Day non-attendance, outlining escalation steps, accountability measures and reporting requirements; signed off by senior management. • Governance document detailing line managers' responsibilities for follow up and resolution • A compliance dashboard/reported generated from ESR or local system, showing trend analysis and intervention actions for repeat non-compliance.
		Medium Priority	**Officer:** Jo Kelso, Head of Workforce Education & Development; Jonathan Sweet, Head of Service Operational Delivery Unit; Gemma Robinson, Workforce Systems Manager **Target Implementation Date:** 31 December 2026
	Theme: Performance Monitoring	Control Operation	

Objective 4: Staff have access to the appropriate training platforms and resources in order to undertake the mandatory training that has been attributed to their role.	**Reasonable**

All EMS, and some ACS staff, have been allocated iPads, which are utilised during shifts to support the undertaking of daily operational tasks, and provide access to ESR, enabling completion of statutory and mandatory e-learning modules. For staff who have not been issued an iPad, access to laptops or desktop computers is available at their designated stations.

However, we were advised that the functionality and user experience of ESR on iPads is limited, making it less practical and efficient compared to using a laptop or desktop. In order to overcome this, the Trust have developed the 'Learn 365' (L365) application within Microsoft Teams, to provide employees with a more tailored and accessible platform to complete their e-learning. L365 allows users to access learning content and pathways directly through the Microsoft Teams interface, on both desktop and mobile devices. A number of further e-learning packages are available for staff providing coverage of content which is required to assist in the completion of their role. Such is available via the On-Click platform and we note that not all of these packages have been migrated to L365 due to resource constraints within the Learning and Development Team, and, at the completion of audit fieldwork, an expected completion date had not been determined (**see Key Finding 4**).

In recognition of the operational pressures faced by staff, the Trust has also implemented MIST Days as a key mechanism for delivering mandatory training. These sessions provide protected time for staff to complete essential face-to-face modules—such as Resuscitation, Moving and Handling, and Violence and Aggression—which may otherwise be difficult to complete during routine shifts. However, several training sessions are cancelled each year due to low attendance, often caused by staff booking-on but failing to attend. This issue has been escalated to the Quality Management Group (see objective 5)

As referenced in objective 1, operational staff are allocated 37 CPD hours annually to support broader professional development, including learning new skills or enhancing existing ones. While guidance and associated application forms are available to support access to CPD opportunities, there is no central repository or system in place to monitor how this time is utilised. As a result, there is limited assurance that CPD time is being used appropriately, and no mechanism to enforce compliance with expectations for unused CPD hours i.e. financial reimbursement or additional shift work.

Key Findings		Risk & Impact	Agreed Management Action
4	**Limitations in Remote Access and Integration of E-Learning Platforms** The Trust identified limitations in accessing ESR e-learning packages via iPads issued to a significant proportion of the operational workforce. To address this, the Learn365 app, accessible through the Microsoft Teams platform, has been adopted to improve access to e-learning. Although all relevant staff now have access to the Learn 365 platform, we note that not all e-learning modules are currently available on the platform. This is not limited to the modules from ESR – rather additional training modules, required to be completed to allow staff members to undertake their roles effectively, that are available on a further platform (On-Click). As a result, staff have been accessing three platforms to maintain full compliance. We were advised that the delay in transitioning fully to Learn365 is primarily due to resource constraints within the Learning and Development Team and the need to update training content. In addition, while compliance reports can be generated from Learn365, the lack of data integration with ESR means that updates must be manually entered into ESR three times a week – a process described as time consuming and inefficient.	Limited access and integration between Learn365 and ESR may lead to inconsistent training compliance data, increased administrative burden, and delays in ensuring staff meet statutory and mandatory training requirements—potentially affecting workforce readiness and assurance reporting.	**Agreed Action:** • Provide clear guidance to staff on how to navigate the training platform. • Complete the systems migration onto one platform and ensure it is fit for purpose and easily accessible on iPads and mobile devices. • Explore options for automating data transfer between Learn365 and ESR to eliminate manual updates, reduce administrative burden and improve data accuracy. • Develop regular communications to managers and teams on the need to complete training in a timely way. • Produce reports for sharing with managers on training completions and escalate to senior managers where necessary. **Expected Evidence of Implementation:** • Communications issued to staff regarding platform use and compliance. • Evidence of system migration and design discussions/ accessibility requirements for mobile devices. • Technical feasibility report outlining integration options and automation proposals vs manual data entry frequency and associated resource impact. • Copies of communications sent to managers and staff reminding them of training deadlines. • As per KF3, a compliance dashboard/reported generated from ESR or local system, showing trend analysis and intervention actions for repeat non-compliance.
		Medium Priority	**Officer:** Jo Kelso, Head of Workforce Education & Development; Gemma Robinson, Workforce Systems Manager **Target Implementation Date:** 31 December 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 5: There is regular monitoring and reporting of training compliance throughout the Trust, with effective initiatives in place to improve areas with low compliance levels.	**Reasonable**

The reporting framework includes the following components:

- MIST Compliance Task and Finish Group (MCTFG): Established in early 2025, the group aims to identify barriers to staff completing MIST and explore ways to improve annual compliance across all staff grades. Meetings are held as needed, with outputs tracked via an action log rather than formal minutes. Each action lists an owner, review date and completion date. We note that the terms of reference do not specify a reporting route.
- The Quality Management Group (QMG) is a weekly advisory body focused on patient safety and clinical improvement and its oversight spans four key service areas: EMS, EMSC, EPRR & Volunteers; Integrated Care; Ambulance Care; Resourcing & Corporate Services. Its functions include, advising on quality-related decisions; reviewing Learning from Events reports; approving content for the Quality Newsletter; monitoring arrangements related to quality improvement, communication, and training compliance. The Learning Development provide a training compliance update at each weekly meeting.
- Senior Operations Team (SOT): whilst not defined as a formal reporting route within the MCTFG terms of reference, we were advised that any matters requiring escalation are taken to the SOT. We reviewed the minutes from the two meetings where MIST compliance was most recently discussed (in November 2024 and May 2025), and there is also evidence to support some reporting from the MCTFG. Additionally, MIST compliance is reported to the Senior Leadership Team (SLT) via fortnightly AAA (Alert, Advise, Assure) reports, which provide updates on upcoming sessions, the number of places booked, and session availability.
- People & Culture Committee: The People & Culture Metrics Scorecard includes cumulative rates of attendance at MIST days and wider training compliance. Similar data is presented within the Monthly Integrated Quality and Performance Report (MIQPR), which is shared with all Board-level Committees and Trust Board.

The most recent MIQPR indicated reported a combined Statutory & Mandatory Training compliance rate of 88.98% as at July 2025, exceeding the Welsh Government target of 85% for the eighth consecutive month. Several individual areas also met or exceeded the target, including Dementia Awareness (98.50%), Moving & Handling (95.93%) and Safeguarding Adults (95.61%). However, the following areas remain consistently below target:

- Fire Safety 80.97% (renewal every 2 years)
- Paul Ridd 79.27% (Introduced Feb 2023; no requirement to renew)
- Fraud Awareness 80.91% (Introduced Aug 2023; renewal every 3 years)
- Violence Against Women, Domestic Abuse & Sexual Violence 76.42% (Introduced Jan 2017; renewal every 3 years)
- Welsh Language Awareness 74.67% (Introduced Apr 2023; renewal every 3 years)

In respect of local reporting arrangements, the Operations Business Manager advised that fortnightly emails are issued by the Business Support Officers to localities, providing updated MIST compliance rates. While training and compliance are reportedly discussed during local informal catch-ups, there is no defined process to report back on actions taken. (**see Key Finding 3**)

Towards the end of the training year, the Learning and Development team issues emails to localities and regions identifying employees who have not attended their MIST Day. However, there is minimal evidence of remedial action being taken to address repeated non-attendance or where ESR compliance is below target. The only notable exception was the recent improvement in Information Governance training compliance, which was achieved following Board-level intervention, due to potential implications involving the ICO (see objective 3 and **Key Finding 3**).

Appendix A: Summary of Sample Testing

IA Ref	Role	ESR Compliance August 25	Non-compliance dates back to	Attendance at MIST Day			Mitigating reason for non-attendance at MIST day
				22/23	23/24	24/25	
1	Emergency Ambulance Practitioner	88.90%	17/03/2024	✗	✗	✓ - attended as part of Parmaedic induction in year	Attended under induction to new role but persistent non-attendance in previous years
2	Paramedic Band 6	73.30%	01/01/2017	✗	✗	✗	No Mitigating Factors
3	Duty Operations Manager	42.90%	19/10/2019	✗	✗	✗	No Mitigating Factors
4	Paramedic Band 6	73.30%	09/02/2023	✗	✗	✗	No Mitigating Factors
5	Emergency Ambulance Practitioner	75.60%	16/02/2023	✗	✗	✗	No Mitigating Factors
6	Emergency Ambulance Practitioner	34.10%	19/11/2022	✗	✗	✗	No Mitigating Factors
7	Community First Responder Trainer	50.00%	18/10/2016	✗	✗	✗	No Mitigating Factors
8	Paramedic Band 6	71.10%	01/01/2017	✓	✗	✗	No Mitigating Factors
9	Paramedic Band 6	66.70%	10/08/2022	✗	✗	✗	No Mitigating Factors
10	Emergency Ambulance Practitioner	73.20%	01/01/2017	✓	✗	✗	No Mitigating Factors
11	Ambulance Care Assistant 2 (ACA2)	73.20%	01/01/2017	✗	✗	✗	No Mitigating Factors
12	Ambulance Care Assistant 2 (ACA2)	66.70%	14/07/2022	✗	✗	✓ - attended as part of EMT induction in year	Attended under induction to new role but persistent non-attendance in previous years
13	Paramedic Band 6	68.90%	17/02/2023	✗	✗	✗	No Mitigating Factors
14	Paramedic Band 6	75.60%	10/02/2023	✗	✗	✗	No Mitigating Factors
15	Paramedic Band 6	60.00%	15/09/2024	✓	✗	✗	No Mitigating Factors
16	Paramedic Band 6	56.50%	08/05/2024	✓	✗	✗	No Mitigating Factors
17	Emergency Ambulance Practitioner	58.50%	07/03/2021	✗	✗	✗	No Mitigating Factors
18	Paramedic Band 6	68.90%	20/09/2023	✓	✗	✗	No Mitigating Factors
19	Emergency Medical Technician	24.40%	15/10/2023	✓	✗	✗	Career Break
20	Paramedic Band 6	55.60%	08/07/2023	✓	✗	✗	Maternity leave and alternative duties support 24/25 non-attendance
21	Paramedic Band 6	51.10%	13/06/2022	✗	✗	✗	Maternity leave and alternative duties support 24/25 non-attendance
22	Paramedic Band 6	35.60%	15/03/2023	✗	✗	✗	No Mitigating Factors
23	Emergency Medical Technician	46.30%	19/01/2024	✗	✗	✗	Maternity leave and alternative duties support 24/25 non-attendance
24	Ambulance Care Assistant - B2 (NEPTS)	50.00%	12/09/2020	✗	✗	✗	No Mitigating Factors
25	Ambulance Care Assistant (NEPTS)	100.00%	N/A	✗	✗	✗	No Mitigating Factors
26	Ambulance Care Assistant (NEPTS)	17.24%	26/10/2017	✗	✗	✗	No Mitigating Factors - Left Organisation in June '25
27	Ambulance Care Assistant 2 (ACA2)	87.80%	31/12/2023	✗	✗	✓ - attended as part of EMT induction in year	Attended under induction to new role but persistent non-attendance in previous years
28	Ambulance Care Operational Team Leader	80.60%	10/08/2023	✗	✗	✗	No Mitigating Factors
29	Senior APP	68.90%	10/10/2021	✗	✗	✗	No Mitigating Factors
30	Operations Assistant, Community Support	67.50%	06/08/2021	✗	✗	✗	No Mitigating Factors

**This represents the date on which compliance for a particular training module expired, indicating that it has been non-compliant since that point*

Appendix B: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Prioritisation of Findings

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

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

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

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Shared Services Partnership
Audit and Assurance Services

Clinical Equipment

Final Internal Audit Report

2025/26

Welsh Ambulance Service University NHS Trust

Reasonable Assurance

Contents

Review Reference	WAS-2526-05
Fieldwork	July 2025 - September 2025
Executive Sign Off	5 November 2025
Audit Committee	2 December 2025
Executive Lead	Andy Swinburn, Executive Director of Paramedicine
Audit Team	Osian Lloyd, Head of Internal Audit
	Felicity Quance, Deputy Head of Internal Audit

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To evaluate the effectiveness of the arrangements put in place to record, monitor and replace clinical equipment within the Trust.

Overview

A medical device or item of clinical equipment is defined as any apparatus, appliance, software, material or other article, whether used alone or in combination, intended by the manufacturer to be used for a medical purpose. A systematic approach to the acquisition, deployment, maintenance (preventative and performance assurance), repair and disposal of such equipment, alongside appropriate training, is essential to ensure safe, competent and effective use in patient care, and maintain compliance with relevant legislation and guidance.

This review focussed on portable clinical equipment used in patient care and transport. Equipment permanently integrated into vehicle configurations (e.g. stretchers and spinal boards) is managed by the Fleet department in line with the vehicle's seven-year lifecycle and was therefore excluded from the scope of this review. The acquisition, deployment, maintenance and disposal of vehicles was not considered at this review. Further, due to the specialist nature of their equipment, the Hazardous Area Response Team (HART) was also excluded from this review.

We have previously considered clinical equipment at the Trust, and it being safe and effective at the point of use, in the Appropriately Equipped Paramedics report (WAST 1920-16, issued November 2019, limited assurance). It is pleasing to report that significant improvements have been noted in relation to the health and safety concerns that were raised (see objective 4) as well as improvements regarding acceptance testing and the maintenance records held. At this review, we have concluded **reasonable** assurance and the matters require management attention include:

- Policies and Procedures – key gaps were identified in the Medical Devices Policy and associated procedures, including unclear maintenance requirements, reference to a non-existent standardisation policy, and an overdue review of the Disposal Procedure.
- Inventory Listing – the Trust has not implemented the previously agreed recommendation to introduce Radio Frequency Identification (RFID), or as an interim measure, a single centralised clinical equipment list. The absence of an conclusive inventory list was noted to have a wider impact on other objectives, particularly those related to maintenance planning, asset lifecycle management and disposals.
- Equipment Maintenance – maintenance records for clinical equipment remain inconsistent, with gaps in service history, age profiling, and location tracking, particularly for defibrillators, despite improvements since previous audits.
- Datix Reporting – as previously reported incident reporting via Datix is limited at the Clinical Equipment Working Group, reducing visibility of equipment-related issues.

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

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Trust has appropriate policies and procedures in place for the management of clinical equipment, which clearly outline the required roles and responsibilities.	1	**Reasonable**
2	The Trust has a recommended list of clinical equipment from which staff are required to order from.	-	**Reasonable**
3	There is an inventory listing of clinical equipment which is regularly maintained and reviewed.	2	**Limited**
4	Clinical equipment is maintained and kept in an appropriate state of repair; and stored in a safe and secure location when not in use.	3	**Reasonable**

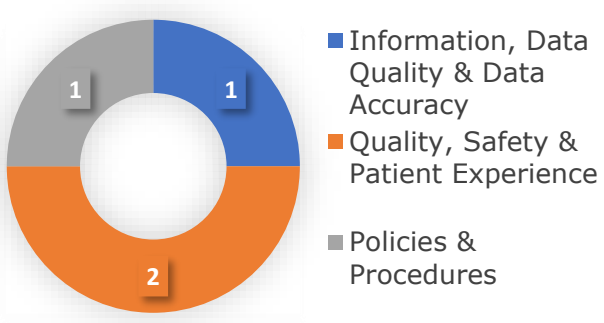
5	Staff receive appropriate training before using medical equipment and devices.	-	**Reasonable**
6	Clinical equipment is appropriately disposed of at the end of their useful life and replaced appropriately.	1	**Reasonable**
7	All incidents, defects and faults relating to clinical equipment are recorded on the Datix incident reporting system; and this information is used to inform future purchasing decisions.	4	**Reasonable**

Management Actions

1
High Priority

3
Medium Priority

Themes



Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: The Trust has appropriate policies and procedures in place for the management of clinical equipment, which clearly outline the required roles and responsibilities.	**Reasonable**

The Trust has the 'Management of Medical Devices' policy in place, which sets out the procedures and responsibilities necessary to ensure the safe, effective and compliant use of clinical equipment across the organisation. Key elements of the policy include:

- Governance Structure – roles and responsibilities are defined for the Chief Executive Officer, Executive Directors, Head of Clinical Logistics, Service Managers and Line Managers.
- Device lifecycle management – guidance on device evaluation, acceptance testing, servicing and replacement; and medical devices inventory and record system (see objective 3).
- Training and Implementation – requirements for user training and safe operational practices.
- Reporting Mechanisms – processes for fault reporting, incident logging and escalation.
- Clinical Equipment Working Group –a brief outline of its remit and reporting lines.

The policy followed the required governance process and was ratified by the Quality, Patient Experience and Safety Committee (QuEST) in August 2024 before publication on the Trust's SharePoint site (Siren). It is led by the Head of Clinical Logistics and overseen by the Executive Director of Paramedicine, with the next review scheduled for August 2027.

Review of the policy noted that it states *equipment purchases should follow a 'standardisation policy'*; however, we were informed that no such policy currently exists. This presents an opportunity to enhance the document by either developing a standardisation policy or revising the reference to reflect current practice (see **Key Finding 1**).

In addition to the policy, is the Trust maintains a dedicated Clinical Equipment section on Siren, which includes user guides for the various devices, such as Mangar lifting cushions.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Gaps in Medical Devices Policy and Associated Procedures** A review of the Management of Medical Devices Policy identified a reference to an equipment 'standardisation policy'; however, it was confirmed that no such policy currently exists within the Trust. It was also noted that the policy does not specify which items of clinical equipment require regular maintenance.	Missing and outdated guidance may result in inconsistent equipment management, safety risks, and	**Agreed Action:** • Update the Management of Medical Devices Policy to ensure it reflects current practice within the Trust, including: clarifying the scope, frequency and responsible parties for equipment maintenance by means of an appendix; and amending the reference to an equipment standardisation policy to clarify the standardisation process managed by clinical equipment working group.

Key Findings	Risk & Impact	Agreed Management Action
Additionally, the Disposal Procedure (see objective 6) is overdue for review, with its last scheduled update dated September 2023.	regulatory non-compliance.	• Conduct a formal review of the Disposal Procedure and update as necessary to ensure alignment with current operational and regulatory requirements. **Expected Evidence of Implementation:** • Management of Medical Devices Policy: Evidence of policy review and updated document for approval by Policy Group • Disposal Procedure: Evidence of procedure review and, if applicable, updated and approved document.
	Medium Priority	**Officer:** Jonathan Wilson, Head of Clinical Logistics / Jason Collins, Head of Financial Management
Theme: Policies & Procedures	Control Design	**Target Implementation Date:** 31 March 2026

Objective 2: The Trust has a recommended list of clinical equipment from which staff are required to order from.	**Reasonable**

Recommended List of Equipment

A list of standard consumables and clinical equipment is maintained within the Trust, developed in line with guidance published by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). These lists specify recommended products, suppliers, order codes, and quantities issued. Amendments to the list are approved at the Clinical Equipment Working Group (CEWG), with evidence of review and approval noted at five meetings held during 2024/25 and 2025/26 to date .

In addition to the overarching list, the Logistics Hub (the hub) maintains tailored equipment lists for each vehicle configuration within the Trust, including Emergency Ambulances, Rapid Response and Non-Emergency Patient Transport. All lists are accessible via the Clinical Equipment section on Siren.

The Head of Clinical Logistics oversees purchases of clinical equipment, with all procurement routed through NHS Wales Shared Services Partnership (NWSSP) Procurement Services. We were informed that any purchase requests initiated outside this process are referred to the Head of Clinical Logistics for approval prior to authorisation.

New Equipment

Selection and procurement of new equipment are made in line with current JRCALC clinical guidelines to ensure alignment with service needs and compatibility with existing assets. The absence of an asset register limits the ability to verify that new equipment is being replaced in accordance with expected lifecycle standards (see **Key Findings 2 and 3**). We evidenced SBAR reports submitted to the CEWG for proposed new equipment, including the NeoMate (a paediatric restraint system), Posey Wrap (for fastening flexible transducers and probe sensors onto patients), and Compact Power Chair), all of which were approved for recommendation to the Ambulance Practice Steering Group.

The CEWG, a workstream of the Ambulance Practice Steering Group, meets quarterly and is responsible for reviewing new equipment proposals, supply chain issues, updates to the consumables and accessories lists; and device-related concerns (see objective 7 for further detail). Proposals are assessed against a range of criteria, including:

- Initial purchase cost (via NWSSP Procurement)
- Ongoing revenue implication, including costs and savings
- Servicing arrangements and associated costs
- Installation requirements
- Training needs and costs
- The cost and availability of consumables and spare parts
- Warranty coverage and cost
- Sustainability and waste considerations

Staff may also submit a ‘Clinical Equipment Proposal Form’ to formally suggest new equipment based on perceived benefits to staff and/or patients, including examples from other Ambulance services. While submissions are infrequent, one example was noted in the July 2024 CEWG meeting, where the introduction of SAM Splints into solo responder Rapid Response Vehicles was proposed and subsequently approved.

Objective 3: There is an inventory listing of clinical equipment which is regularly maintained and reviewed.	**Limited**

Section 6.6 of the Medical Devices Policy (see objective 1) states that *the Clinical Logistics Hub will maintain a comprehensive inventory of all medical devices that have been commissioned via the clinical logistics hub, which includes detailed service history information. This also includes information on items of equipment placed on External Service Contract with outside contractors. A Trust approved contractor may hold this information on the Trust's behalf with an appropriate monitoring system of compliance.*

The '*Appropriately Equipped Paramedics*' internal audit review (WAST-1920-16), highlighted the absence of a single, centralised register of clinical equipment within the Trust. At the time only a defibrillator database maintained by the supplier and accessible via a web portal, was in place. In response, management advised that a business case for an electronic tracking system was being developed, with recognition that significant resources would be required to support equipment identification and tagging.

Review of the internal audit recommendation tracker noted that this recommendation has been marked as closed, citing progress towards implementing a Radio Frequency Identification (RFID) inventory solution for high value clinical equipment. In the interim, electronic records were reportedly developed, including a list of high value items stored at the Hub. However, we were unable to verify the existence or operational use of either control during our review (see **Key Finding 2**).

The Head of Clinical Logistics advised that the Trust is in the early stages of implementing a tagging system for high-value items such as defibrillators, stretchers, carry chairs, and drug boxes (primarily to secure contents rather than the containers themselves). However, no formal timeline for implementation has been established.

Progress has been made at the Hub, where individual equipment lists are maintained for specific items including the Mangar lifting cushions, LUCAS devices (to provide mechanical chest compressions to patients in cardiac arrest), suction units and defibrillators. These lists include identifiable details such as serial numbers and the locality where each device is currently held. However, due to frequent movement between vehicles, precise tracking of equipment location remains challenging. Devices are expected to remain associated with their original issuing station, though this is not always reliably maintained.

A review of the defibrillator database identified 10 units currently marked as 'location unknown', which are considered missing (see **Key Finding 2**.)

Key Findings		Risk & Impact	Agreed Management Action
2	**Lack of Centralised Clinical Equipment Inventory** A key finding from the Appropriately Equipped Paramedics review (WAST-1920-16: Limited Assurance) highlighted the absence of a centralised clinical equipment list. The Trust responded by exploring RFID tracking, and the 2020/21 follow up review (WAST-2021-33), noted progress toward implementing an RFID inventory system for high-value equipment. Meanwhile, electronic records were developed, including a list of high-value items stored at the Hub. The last update in August 2021 set a target date of March 2022 for RFID implementation, but the recommendation was later removed (closed) from the tracker. RFID has still not been implemented. While individual databases now exist for specific equipment types (e.g. Defibrillators, Mangar Cushion, Lucas Devices and Suction Units), a centralised inventory system remains absent. Such a system would support lifecycle tracking and inform procurement decisions for new or replacement equipment.	The lack of a centralised clinical equipment inventory reduces visibility of assets, hindering effective tracking, maintenance and replacement planning. This may lead to equipment related risks, inefficiencies, and missed opportunities for strategic decision making.	**Agreed Action 1:** • Reassess the suitability of RFID to assist in centralised asset management of clinical equipment; • Develop and maintain a Trust-wide centralised database for clinical equipment. Details to include equipment type and location, condition, maintenance schedule, expected lifecycle; and replacement planning. • Consolidate individual databases (Defibrillators, Mangar Cushion, LUCAS devices, suction units) into the centralised system. **Agreed Action 2:** • Implement an Asset Management Software system (such as eQuip) ahead of Scan for Safety Wales.
			Expected Evidence of Implementation 1: • Evaluation of suitability of RFID system against asset management criteria • Populated and active centralised database for all clinical equipment **Expected Evidence of Implementation 2:** • Evidence of an implemented Asset Management Software System.
		High Priority	**Officer:** Jonathan Wilson, Head of Clinical Logistics / Aled Williams, Assistant Director of Digital **Target Implementation Date:** (1) 31 January 2026; (2) 30 June 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 4: Clinical equipment is maintained and kept in an appropriate state of repair; and stored in a safe and secure location when not in use.	**Reasonable**

Acceptance Testing

The Management of Medical Devices Policy requires all new equipment to undergo acceptance testing at the Hub before use, in line with the Provision and Use of Work Equipment Regulations 1998 (PUWER). Testing is supported by standardised forms and instructional videos. Failed items are returned to the manufacturer for replacement. Once testing is complete, equipment testing results are added onto the Trust's database (Dynamic system). A secondary test is conducted before deployment to account for delays between initial testing and issue. Batteries are disconnected during storage to preserve charge, with periodic checks scheduled and spare batteries held on-site for contingency purposes. These processes represent an improvement compared to the findings of our previous internal audit in this area.

Maintenance

Servicing is carried out either in-house at the Hub or via external contracts, with records maintained by both the Trust and contracted providers; again, an improvement compared to the findings of our previous internal audit The current policy does not specify which items require regular maintenance (see **Key Finding 1**). The arrangements for the following items were considered during audit fieldwork:

- **Mangar Lifting Cushions**: These are serviced in-house on a rotational schedule by locality. The Hub coordinates exchanges, verifies serial numbers (reporting any missing items), and logs outcomes using standard forms, including pass/fail status and parts replaced. Our review of the maintenance records provided during the audit confirmed that all items were within their valid inspection or service dates. An age profile database is also maintained to support timely replacement planning.
- **Defibrillators**: These are serviced externally, with monthly reports from the supplier detailing upcoming service dates. Servicing is arranged based on the station of original issue, based on the assumption that while devices may move between vehicles, they remain linked to their issuing station. Replacement units are sent to stations to facilitate the return of those due for servicing. A review of the August 2025 supplier report showed 59 of 550 units were overdue for servicing. The report does not include age profiling (see **Key Finding 3**).
- **Lucas Devices**: These items are serviced externally, with service history and upcoming service dates recorded in a database accessible to the Trust. Our review of the database confirmed that all items were currently within their valid service periods.

Storage

Opened in 2020, the Caerphilly Clinical Logistics Hub provides secure, climate-controlled storage with restricted access and capacity for up to 490 pallets. Compared to the previous Hensol facility, the new purpose-built hub offers improved conditions for equipment, PPE and uniforms. A visit to the Caerphilly Logistics Hub identified that the equipment was stored safely and securely whilst awaiting placement.

Equipment in the field is mainly stored on Trust vehicles, with limited spares held at ambulance stations for urgent replacements. A site visit to Cwmbwrla station confirmed secure practices, including locked storage areas and designated zones for faulty equipment awaiting return.

The Trust has effectively addressed the health and safety concerns identified during our previous internal audit. Furthermore, our recent site visits did not reveal any additional areas of concern.

Key Findings		Risk & Impact	Agreed Management Action
3	**Inconsistent Maintenance Records** Servicing of clinical equipment is carried out either in-house or via external contracts, with records maintained by both the Trust and suppliers—an improvement from previous audit findings. However, gaps remain: • Defibrillators: Serviced externally, with monthly reports listing only upcoming service dates. The August 2025 report showed 59 of 550 units (11%) overdue for servicing. The report lacks service history and age profiling, limiting oversight of lifecycle status. • Mangar Lifting Cushions: Serviced in-house on a rotational schedule. Records reviewed during the audit confirmed all items were within valid service dates. An age profile database is maintained to support replacement planning. • Lucas Devices: Serviced externally, with service history and upcoming dates recorded in a Trust-accessible database. All items were within valid service periods at the time of review. The current policy does not specify which equipment requires regular maintenance (see Key Finding 1), and 10 defibrillators were listed with 'unknown' locations, indicating potential loss or tracking issues.	Equipment is not serviced regularly to ensure it is fit for purpose and is therefore more likely to fail, potentially compromising patient safety and clinical effectiveness.	**Agreed Action:** • Improve maintenance records to ensure service reports include both historical and upcoming service dates. • Investigate the defibrillators overdue for servicing and ensure prompt scheduling • Include details of equipment age and expected lifecycle within the centralised database to support replacement planning (see **key finding 2**). • Clarify maintenance requirements to specify which items require regular servicing and by whom (see **key finding 1**). • Investigate missing equipment and strengthen location tracking controls (see **key finding 2**). **Expected Evidence of Implementation:** • Updated service reports showing both historical and upcoming service dates. • Confirmation that overdue units have been serviced or scheduled, with supporting records. • Database entries showing equipment age and expected lifecycle details. • Revised Medical Devices Policy specifying maintenance requirements and responsible parties. • Updated inventory records resolving 'unknown' locations and documentation of tracking enhancements.
		Medium Priority	**Officer:** Jonathan Wilson, Head of Clinical Logistics **Target Implementation Date:** 28 February 2026
	Theme: Quality, Safety & Patient Experience	Control Operation	

Objective 5: Staff receive appropriate training before using medical equipment and devices.	**Reasonable**

Operational staff receive training relevant to their respective roles, including the use of clinical equipment.

The approach to training varies depending on whether the equipment is entirely new or a modification of existing tools. Delivery methods include clinical bulletins, Mandatory In-Service Training (MIST) days, e-learning modules; and local instruction by clinical team leaders or operational tutors.

Recent examples include:

- Ferno NeoMate: A paediatric restraint system designed to safely and securely transport infants and young children on ambulance cots. To support its rollout, a clinical bulletin was issued to inform staff and a dedicated e-learning module was made available on Learn 365.
- PAX Carry Sheet: A lightweight and versatile rescue aid procured for every emergency vehicle across the Trust following recommendations from the Manchester Arena Inquiry. Training was incorporated into the 'Safer Handling' session of the 2024/25 MIST days via a PowerPoint slide.

Through our audit of MIST (WAS-2526-17) we have raised findings regarding routine attendance at the scheduled days; and have not sought to replicate at this report.

Objective 6: Clinical equipment is appropriately disposed of at the end of their useful life and replaced appropriately.	**Reasonable**

The Trust has a standard operating procedure for the disposal of both clinical and non-clinical equipment, ensuring compliance with relevant legislation, including the Environmental Protection Act, Waste (England & Wales) Regulations 2011, Hazardous Waste Regulations 2005; and the Control of Substances Hazardous to Health Act (COSHH). The expected useful economic life of clinical equipment is seven years.

The guidance details disposal routes and methods (general waste, contractor collection, manufacturer returns, and auction) and includes a comprehensive item list and departmental contacts. Although issued in September 2022 with an annual review cycle, the procedure is now overdue for review (see **Key Finding 1**).

As highlighted in our Appropriately Equipped Paramedics review (WAST-1920-16), the Trust does not have an asset replacement programme in place. In the absence of a comprehensive equipment inventory (see **Key Finding 2**), there is a risk of unnecessary expenditure due to premature replacement—particularly for vehicle-installed equipment, which is expected to last the full vehicle lifecycle (approximately seven years).

Disposal Log

The Hub maintains a monthly disposal log capturing equipment details, reason for disposal, evidence of damage or negligence, disposal date, and the authorising officer. A sample review of ten items (four Mangar cushions and six suction units) confirmed appropriate logging and disposal following maintenance failure.

Income Maximisation

The Head of Clinical Logistics recently amended the disposal route for decommissioned Corpuls defibrillators due to reduced auction value and demand. An SBAR submitted to, and approved by, the Executive Director of Finance & Corporate Services supported a supplier buy-back arrangement for the decommissioned items. This generated £93k for 35 units, exceeding the auctioneer's reserve price and providing a consistent income stream.

Objective 7: All incidents, defects and faults relating to clinical equipment are recorded on the Datix incident reporting system; and this information is used to inform future purchasing decisions.	**Reasonable**

Incidents, defects or faults relating to clinical equipment should be reported via the Datix incident reporting system. However, during fieldwork, we were not provided with a report to support that this process is consistently followed. A review of the CEWG papers and associated AAA reports failed to identify regular reporting on Datix incidents (see **Key Finding 4**). That said, we did note that a recent presentation was given to the group prompted by an increase in Datix entries related to failures of the Optical Airtraq (a disposable optical laryngoscope). The presentation outlined that the Trust sought advice from the manufacturer as well as undertaking their own testing, with conclusions and possible solutions recommended to the CEWG for discussion. It is anticipated that any such issues will help inform future purchasing decisions – there was no evidence available that suggested otherwise

Issues with equipment will typically be identified through safety notices or field summary notices issued by the NWSSP Procurement Team. These are sent to the Head of Clinical Logistics via the Clinical Logistics central email address and subsequently disseminated across the organisation with appropriate actions outlined. For example, in June 2025, a recall notice was issued for Intersurgical Guedel Airways OPAs (which maintain an airway in unconscious patients by lifting the tongue). The Hub responded by circulating the notice organisation-wide, along with guidance on returning the affected items to the Hub for onward return to the supplier.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Limited Use of Equipment-Related Incident Data** A review of the minutes and papers for the Clinical Equipment Working Group (CEWG) identified occasional references to equipment-related incidents, typically as part of wider discussions on specific items. For example, a presentation was delivered to the group in response to an increase in Datix reports concerning failures of the Optical Airtraq device. However, Datix reports relating to equipment-related incidents are not routinely received or reviewed by the CEWG. This limits the group's ability to systematically monitor trends, identify recurring issues, and use incident data to inform decision-making around equipment management and procurement.	The absence of routine review of Datix equipment incidents by the CEWG may result in missed trends, delayed responses to recurring issues, and less informed decisions on equipment procurement and safety.	**Agreed Action:** • Ensure Datix reports related to equipment incidents are routinely submitted to and reviewed by the CEWG. • Add a standing agenda item to CEWG meeting agendas for reviewing equipment-related incidents. • To facilitate trend analysis and strategic planning, implement a dashboard/summary tracker of equipment related Datix reports highlighting frequency of incidents, types of equipment involved, severity and outcomes; and actions taken. **Expected Evidence of Implementation:** • CEWG meeting agendas, papers and associated actions/minutes. • Tracker of equipment-related Datix reports
		Medium Priority	**Officer:** Jonathan Wilson, Head of Clinical Logistics **Target Implementation Date:** 31 December 2025
	Theme: Quality, Safety & Patient Experience	Control Design	

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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

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

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

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

Public Sector Internal Audit Standards

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

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

IMTP Development Process

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust

Substantial Assurance

Contents

Review Reference	WAS-2526-07
Fieldwork	July - August 2025
Executive Sign Off	9 October 2025
Audit Committee	2 December 2025
Executive Lead	Executive Director of Strategy, Planning & Performance
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

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

Executive Summary

Purpose

Review of the process undertaken for the development of the Integrated Medium-Term Plan (IMTP), including the mechanisms to identify priorities, engagement with stakeholders and alignment to national criteria.

Overview

The NHS (Wales) Act 2006 sets out the requirements for NHS Planning in Wales. Under the legislative framework, local health boards and NHS trusts have a statutory duty to prepare a three-year IMTP that sets out how they will comply with their financial break-even duties while improving the health of the people for whom they are responsible.

The Wellbeing of Future Generations (Wales) Act 2015 sets in law the need to consider the long-term strategic approach to deliver a better future. This is underpinned by 'A Healthier Wales', which remains the vision and long-term plan for health and social care in Wales. We acknowledge that the Welsh Ambulance Services University NHS Trust (the Trust) was required to comply with this Act for the first time from 30 June 2024 and has set its wellbeing objectives for 2025/26.

The Trust's IMTP (2025-2028) was approved by the Board on the 27 March 2025 prior to submitting for approval by Welsh Government in accordance with the timelines set. Formal approval of the IMTP was received from Welsh Government on 30 June 2025.

Welsh Government has approved changes to the Ambulance Performance Framework that introduces new prioritisation categories and amending existing ones, with greater focus on clinical outcomes and quality of care. These changes will need to be considered as part of planning for the IMTP (2026-29). Additionally, arrangements with the NHS Wales Joint Commissioning Committee (NWJCC) are still developing, which may impact the Trust further.

While our focus was on the last IMTP planning process (that occurred during 2024/25), business continuity was discussed due to key staffing changes within the Strategy, Planning and Performance Directorate. The Director has taken up the position of interim CEO from July 2025 until 1 October 2025, with the Director of Partnerships and Engagement providing cover during this period. An Interim Deputy Director of Planning and Performance is also in place. Two key employees, including the Assistant Director of Planning and Transformation, are leaving the Trust, and a member of staff is on a period of long-term absence. Discussions identified that a transition plan has been developed that includes identifying a member of staff with the required skills and experience to oversee the next IMTP planning cycle.

Some financial aspects have been considered during this audit, however, a detailed review of financial planning will be included as part of our budget-setting audit, included within the 2025/26 Internal Audit plan.

We have concluded substantial assurance on this area. The Trust adopts a structured project management approach to IMTP development, supported by documented guidance. This ensures that key elements of the planning process are undertaken, such as stakeholder engagement and the capturing lessons learnt, and has enabled the IMTP to be submitted to the Trust Board and Welsh Government within the set deadline. The matters requiring management attention include:

- Given the pace and scale of transformational activity within the Trust, enhancements are needed within the planning process to ensure there is sufficient resource capacity to support effective delivery of the IMTP when new deliverables emerge during the year; actions are appropriately prioritised; and there is clear rationale for inclusion on the IMTP.
- Improvements are required in the application of the Project Path Framework (PPF) to ensure consistency and appropriate oversight of revenue funding decisions.
- Clarification of responsibilities and timescales to prevent delays with the IMTP development. Full details of matters arising are detailed within the Findings & Agreed Action Plan. During the course of fieldwork, we also noted that it would be beneficial for the circulation of the IMTP project highlight reports to be extended to the newly established steering group to support oversight. We have highlighted this for management information and does not impact the overall opinion.

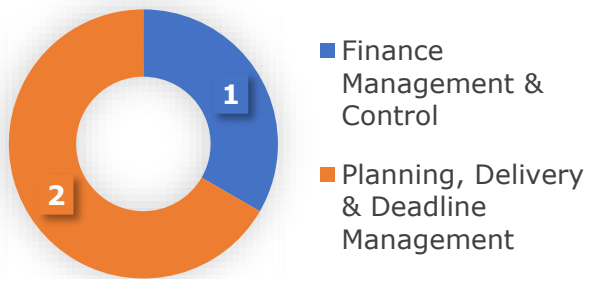
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Trust has an appropriate planning approach to ensure key priorities are identified for the IMTP that have clear measurable targets and actions towards delivery of the ministerial priorities.	1, 2, 3	**Reasonable**
2	Key priorities are aligned to other health boards' plans and the criteria set out in the NHS Wales Planning Framework.	-	**Substantial**
3	The Trust has a process for identifying key stakeholders when undertaking IMTP planning and ensures they are actively engaged.	-	**Substantial**
4	Appropriate governance arrangements are in place, which provide effective oversight of the planning process, ensuring the IMTP is subject to scrutiny and review prior to submission to Welsh Government.	3	**Reasonable**

Management Actions

0	3
High Priority	Medium Priority

Themes



Risk Types

Public Perception & Reputational Risk

Financial Loss

Findings & Agreed Action Plan

Objective 1: IMTP priorities are defined, with clear measures, targets and actions or delivery	**Reasonable**

Planning

IMTP development is undertaken by a dedicated team using a formal project management approach (running from July to March). Key elements include the *State of the Nation* report (establishing a baseline of the Trust's current position at September 2024 following the Board's previous IMTP approval in March 2024), collaborative planning (identifying key risks, emerging priorities and the financial context), prioritisation, engagement, and governance.

The IMTP planning process is supported by annually updated guidance, which is currently under review and will soon be hosted on a new Integrated Strategic Planning and Development (ISPD) SharePoint site. We note that the Planning Framework (June 2023) is being updated but current practices remain extant with the document accessible to all staff on Siren.

The Quality and Performance Management Framework details that planning should be undertaken at a directorate level to support IMTP delivery. Directorates maintain three-year plans, which are reviewed annually, but submissions have been inconsistently applied. A redesigned, digitised template, developed from user feedback, is available on the new SharePoint site for the next IMTP planning cycle (to be carried out during 2025/26).

IMTP Delivery Programmes were replaced by the Clinical Model Transformation (CMT) Board, who collect IMTP-related data from its workstreams using a dedicated template. While this approach is still embedding, there is recognition that there needs to be clearer delineation between CMT and directorate plans so there will be improvements to directorate reporting to prevent duplication in future planning cycles.

Prioritisation

The Trust has adopted the MoSCoW (Must have, Should have, Could have, Will not have right now) technique for prioritising resources to IMTP deliverables. Two prioritisation workshops were held in January and February 2025 involving members of the Executive Leadership Team (ELT), directorate leads, and trade union representatives focussing on forthcoming priorities and associated costs and resources. From review of the relevant supporting documentation, it was difficult to track the prioritisation status of submissions, particularly those carried forward from previous years (see **Key Finding 1**). Given that there will be new staff within the Planning team and the continued scale of transformational change across the Trust impacting staff capacity, the rationale for including carried-forward actions needs to be clearly articulated to maintain strategic alignment and the effectiveness of the planning process (see **Key Finding 1**).

Funding

The Project Path Framework (PPF), aligned with the UK Government's 'Five Case Model,' provides a structured approach for developing project specifications and revenue business cases for investments exceeding £50,000. However, its effectiveness is currently limited due to insufficient documentation and a lack of awareness, which may lead to inconsistent application (see **Key Finding 2**).

Timeframe

While the IMTP Planning Guidance included a high-level timeline, the project plan lacked sufficient detail in clarifying responsibilities and timescales, which contributed to delays in the development of the 2025-28 IMTP (see **Key Finding 3**).

In its Structured Assessment of the Trust (November 2024), Audit Wales highlighted that although the Finance and Performance Committee (FPC) and the Board were kept informed of the IMTP's progress, neither had the opportunity to review a full draft until March 2024, when it was

formally approved for submission to Welsh Government. In response, and in line with the agreed management action, Non-Executive Directors (NEDs) were emailed a copy of the IMTP in March 2025, ahead of the submission deadline. While this represented an improvement, the planned timescale for circulating the draft IMTP was missed, and NEDs were not formally notified of the delay (see **Key Finding 3**).

Minimum Data Set (MDS)

Welsh Government provides a MDS template to capture numerical information of operational activity and outcomes, workforce plans, and financial plans. Discussions with the officers involved in the process confirmed that independent data validation checks are undertaken to ensure alignment across the required data sets and the IMTP narrative. Following Welsh Government's review, no significant changes were required to the Trust's MDS submission.

Lessons Learnt

The planning approach for the 2025-28 IMTP was revised to incorporate key lessons learned from the previous cycle. Areas for improvement from the current IMTP exercise have been shared with ELT (30 July 2025), with particular emphasis on improving communication, e.g. requests for input were sometimes unclear or inconsistent, and deadlines were not always communicated effectively or early enough.

Key Findings		Risk & Impact	Agreed Management Action
1	**Lack of Consolidated Tracking** The Trust is experiencing an increasing volume of transformational change both internally and externally (such as with the NHS Wales Joint Commissioning Committee (NWJCC) and the Ambulance Performance Framework) that impacts resource capacity. As new deliverables emerge throughout the year, there is a need to strengthen how these are recorded and prioritised. The absence of a consolidated tracker means there is currently no robust mechanism to clearly determine the: • **Number of Submissions** – no document was provided during the audit that clearly records all IMTP submissions received and their prioritisation. • **IMTP Actions Carried Forward –** there is limited recording and visibility of the number of IMTP actions carried forward and how they are prioritised alongside new deliverables. For example, at the January 2025 prioritisation workshop, it was reported that 48 actions were rolling forward into 25/26 - *14 prioritised as must do's, 32 as should do's, 1 could do, 1 not categorised. Many confirming as deliverable in Q1*. While fluctuations in carried forward actions are expected as the IMTP plan is being drafted, there was a lack of clarity and reconciliation with those highlighted at the workshop compared to Finance & Performance Committee (FPC) reporting (20 May 2025) of IMTP actions carried forward, e.g. 17 directorate-led actions have been carried forward to the IMTP (2025-28), but the number of CMT-specific IMTP priorities were unclear. • **Rationale** – the Integrated Strategic Planning & Development Group (ISPD) highlight report to the Strategic Transformation Board (STB) on 20 December 2024 detailed that approximately 25% of current IMTP actions were being carried forward into 2025/26, contributing to an already overburdened work plan with 152 new actions. The reason for including actions within the IMTP, particularly where priorities have shifted or are being carried forward has not always been clearly defined, e.g. continual development and implementation.	Insufficient capacity to deliver the IMTP may lead to ineffective performance reporting, delayed delivery of priorities and reduced assurance for decision makers. **Medium Priority**	**Agreed Action:** • Design and implement a centralised digital tracker to record and monitor all IMTP deliverables. The tracker will include a clear process for capturing prioritisation decisions, (e.g. deliverables to be carried forward/closed/amended) along with clear lines of accountability and reporting across committees and directorates. • Establish and communicate a clear and structured process for responding to organisational changes or new emerging priorities that may impact delivery of existing IMTP deliverables to support consistent decision-making and resource allocation. • All IMTP deliverables to be assigned with a robust referencing number to align the IMTP document and digital tracker. **Expected Evidence of Implementation:** • Centralised Digital Tracker • Change Control Process **Officer:** James Houston (Assistant Director of Planning & Transformation)

Key Findings		Risk & Impact	Agreed Management Action
	Theme: Planning, Delivery & Deadline Management	Control Design	**Target Implementation Date:** 31 December 2025
2	**Project Path Framework (PPF) Application** Although the PPF business case process was formally approved by ISPD on 22 March 2024, it was not applied during the 2024/25 IMTP planning cycle. Funding decisions were appropriately escalated for approval, e.g. ELT, however, the Framework's use was limited due to a lack of communication, supporting templates, and a mechanism to record submissions, limiting consistency and oversight.	Inconsistent processes and limited awareness may result in reduced accountability and oversight, resulting in variable application of the PPF, inconsistent revenue investment decisions, and missed opportunities to apply a structured, evidence-based approach.	**Agreed Action:** • Review and implement the business/investment case submission process as part of the wider review of the IMTP Delivery approach for 2026-29. • Update IMTP Planning Guidance for 2026-29 to reflect revised approach and build into project plan.
			Expected Evidence of Implementation: • IMTP Planning Guidance • IMTP Project Plan
		Medium Priority	**Officer:** James Houston (Assistant Director of Planning & Transformation)
	Theme: Finance Management & Control	Control Design	**Target Implementation Date:** 31 December 2025

Key Findings		Risk & Impact	Agreed Management Action
3	**Timeframes and Delays to IMTP Development** While a project management approach was adopted, project planning lacked clarity around key responsibilities and timescales contributing to delays in the development of the 2025-28 IMTP (see Appendix A): • **IMTP Project Team:** Attendance at project team meetings was generally good, but varied across directorates, with some (People & Culture and Quality, Safety and Patient Experience) showing a notable trend of lower engagement. • **Project Plan:** An email to the team (9 December 2024) requested initial IMTP narrative sections to be drafted by 13 December 2024. However, the Project Plan detailed some of these tasks with deadlines at the end of January 2025 impacting the first IMTP draft, which was due 31 January 2025. The Plan has not been updated to record when the IMTP narrative sections were completed. Other key milestones, such as directorate plan submissions, CMT workshops, and draft IMTP reporting dates are also not recorded. • **Operational Delays:** There was a delay in directorate plans being submitted and CMT workshops were scheduled late January 2025 despite the first IMTP draft being due 31 January 2025. IMTP project reporting to ELT (12 February 2025) noted that IMTP narrative requests had a 'Red' RAG status as there were few deliverables identified for years 2 and 3, and year 1 lacked SMART objectives. • **Reporting Delays:** Reporting to Non-Executive Directors (NEDs) was delayed. Initially scheduled for the week commencing 17 February 2025, the draft was not shared until 3 March 2025. There was no formal communication issued to notify them of the delay.	Unclear timeframes and responsibilities may hinder timely input and review, leading to delays in the IMTP's development and potential impact on the submission to Welsh Government.	**Agreed Action:** • Review the IMTP project delivery arrangements and membership to ensure appropriate attendance and engagement across the organisation. • Detailed IMTP project plan to be developed with key leads identified, setting out clear responsibilities and milestone dates. • Embed a regular and robust monitoring and progress reporting process as part of the IMTP development project arrangements. Risks to be reported and escalated through the IMTP governance structures including cause, impact and proposed mitigation strategies.
			Expected Evidence of Implementation: • IMTP Development Group (Terms of Reference) • IMTP Project Plan • IMTP AAA reporting
		Medium Priority	**Officer:** James Houston (Assistant Director of Planning & Transformation)
	Theme: Planning, Delivery & Deadline Management	Control Operation	**Target Implementation Date:** 31 December 2025

Objective 2: Priorities align with other health boards and national planning criteria.	**Substantial**

The NHS Wales Planning Framework for 2025–2028 outlines the Cabinet Secretary's five strategic priorities (Timely Access to Care, Population Health and Prevention, Building Community Capacity, Mental Health Access, Women's Health). The Trust submitted the required ministerial templates for four of the five priorities, and assurance against the delivery of these were reported to FPC (21 July 2025). The Women's Health template was not completed as the delivery expectations focused on Women's Health Hubs which are not applicable to the Trust. Nonetheless, regular progress updates are provided to Welsh Government, including plans for maternity and neonatal support, and a lead midwife was permanently appointed this year, which had previously been a key IMTP action.

The Planning Framework details enabling actions to support delivery in areas such as digital innovation, workforce development, and financial sustainability. The Trust has identified relevant enabling actions and incorporated them into IMTP deliverables. For example, the implementation of a community-based falls response forms part of the Six Goals Programme and is reported under CMT delivery. A verbal update on progress will be provided to FPC on 16 September 2025, with written updates on the delivery of enabling actions planned for future meetings.

Welsh Government has approved the IMTP, although formal feedback on the submission has not been provided. The Trust received its accountability conditions on the 28 July 2025 and reporting to FPC on 16 September 2025 will outline how these are being addressed.

To support alignment of the Trust's IMTP with other NHS organisations, quarterly meetings are held with Digital Health and Care Wales to forward plan their Joint National Plan. Health boards also attend the NWJCC's Interim Ambulance Care and 111 Commissioning Group meetings. IMTPs are shared within a dedicated channel for Assistant Directors of Planning (ADOPs), where all NHS Wales organisations are represented. Health board IMTP priorities focus on urgent and emergency care, supported by a dedicated programme board which the Trust attends.

Reporting to Trust Board on 30 January 2025 highlighted a risk that the Integrated Commissioning and Planning (ICAP) meetings with health boards (that previously formed part of the Emergency Ambulance Services Commissioner (EASC) structure) had been stood down due to a change in the commissioning arrangements. No alternative arrangements have yet been established within the NHS Wales Joint Commissioning Committee (NWJCC), which is still developing its governance framework. While this is outside of the Trust's control, oversight of the risk has been maintained through ISPD highlight reporting to STB and ELT monitoring through its risk register.

Following a review of the previous IMTP cycle, Welsh Government noted significant variation with NWJCC commitments and risks not being clearly identified or addressed in health board plans and highlighted the need for greater clarity in service commissioning. Examples of good practice were identified for each organisation, with the Trust's plan commended for having a clear and comprehensive approach to delivering the falls framework.

Objective 3: Stakeholders are identified and actively involved in planning.	**Substantial**

The Trust has embedded stakeholder engagement at an early stage of the IMTP development process through a range of mechanisms. Phase 1 of the engagement plan (up to the end of September 2024) included staff and patient feedback captured through the *State of the Nation* report and a collaborative planning event held on 2 October 2024. Staff feedback was gathered through 'WAST Live' (that provides an opportunity for staff to ask ELT questions), surveys and other methods. Key themes emerging from the engagement included training and career progression, staff welfare and working conditions, and patient care and service delivery. These themes are incorporated in several IMTP deliverables under Strategic Objective 2: Enabling our people to be the best they can be.

Patient and public engagement was facilitated through the Patient Experience and Community Involvement (PECI) team. Feedback highlighted the Trust's kind and caring staff and the quality of clinical care provided. However, several priority areas were identified including in relation to reducing ambulance delays in emergency response, improving transparency in communication, promoting inclusivity (which are being progressed through IMTP delivery within the CMT programme), addressing capacity challenges within the 111 service, and raising awareness of injury prevention, such as falls, aligning with the Trust's Population Health Plan.

Trade union engagement has been provided through opportunities to attend the collaborative planning event, prioritisation workshops, and IMTP project team meetings. Regular updates were also provided to the Corporate Partnership Forum and the Welsh Ambulance Services Partnership Team (WASPT) in January and March 2025.

Despite interim arrangements (see Objective 2) and the NWJCC being in its infancy, there has been sufficient consultation and information sharing throughout the IMTP's development. The IMTP Planning Guidance details the commissioning timeframes, including a development session in October 2024, where key Trust risks were considered. The Trust has provided several updates (evidence provided for October 2024, February and March 2025) to the NWJCC Interim Ambulance and 111 Commissioning Group, whose members attended the collaborative planning event. Further, the IMTP submission to Welsh Government includes Appendix 6, a letter of support from NWJCC, which acknowledges the Trust's intention to break even during the 2025-26 financial year, contingent on the successful delivery of a significant cost reduction programme.

Objective 4: Governance ensures effective oversight and timely review of the IMTP.	**Reasonable**

A dedicated IMTP project team met at least fortnightly through the planning cycle, although attendance varied across directorates (see **Key Finding 3**). For the first time during the 2024/25 planning cycle, bi-weekly IMTP project highlight reports were introduced and shared with key individuals involved in IMTP planning. Extracts from these reports were also shared with ISPD and presented at ELT on 12 February 2025, noting an overall project RAG status of 'Green'. However, as highlighted in **Key Finding 3**, some directorates had yet to submit their narratives, and several deliverables required further refinement to ensure they were fully populated and SMART.

The ISPD meets every six weeks and reports to STB using the 'Alert, Advise, Assure' (AAA) framework. Oversight of IMTP development was appropriate, with updates provided on prioritisation, actions carried forward, and key risks - particularly relating to delays in directorate planning and CMT workshops.

The original intention was to present an early version of the IMTP to NEDs by the end of January 2025. The deadline was later revised to mid-February 2025, but in practice, reporting occurred in early March 2025 (see Appendix A and **Key Finding 3**), following a decision taken not to share an incomplete draft. NEDs were not formally notified of the delay. Despite this, Trust Board and FPC were kept informed throughout the process via Board development days (November and December 2024) and regular updates on the progress with the development of the 2025-28 IMTP. We note that the IMTP project team is amending the timeline for the next IMTP cycle to assist with earlier reporting.

The final draft of the IMTP was submitted in line with the project timeline, with reporting to ELT (5 March 2025); FPC (18 March 2025); and Trust Board (27 March 2025), where the IMTP was formally approved for submission to Welsh Government. The Financial Plan for 2025/26 was also endorsed, acknowledging its ambitious nature and the potential impact on service delivery and patient safety, as there are efficiency targets of £8.5 million, with associated risks linked to potential additional savings requested by the NWJCC.

Reporting to FPC on 21 July 2025 confirmed that the Trust's IMTP was submitted to Welsh Government by the agreed deadline of 31 March 2025, with formal approval received on 30 June 2025.

For the upcoming planning cycle (to be carried out during 2025/26), governance arrangements are being strengthened through the introduction of a steering group with director representation, reporting into ISPD. This will provide a formal escalation route for issues such as delays in key project tasks or inconsistent attendance at project team meetings. It would be beneficial for the circulation of the IMTP project highlight reports to be extended to this group to support oversight.

Appendix A: IMTP Reporting Timeframe

	Dates	Detail
Reporting to Integrated Strategic Planning & Development (ISPD)	8 November 2024	The IMTP Planning Guidance details that directorate planning will be undertaken between August and September 2024. ISPD highlight reporting to the Strategic Transformation Board (STB) notes that the deadline for directorate priorities was extended to the end of October 2024 though not all submissions had been received. The report also highlights a risk that CMT workshops were scheduled for late January 2025, after the first prioritisation workshop (08/01/25), and close to the deadline for completing the first draft of the IMTP.
Reporting to Executive Leadership Team (ELT)	18 September 2024	Key areas of IMTP focus.
	4 December 2024	Planning and engagement session
	12 February 2025	The first draft of the IMTP was presented to ELT as per the IMTP project timeline but notes that some narratives are still outstanding.
	5 March 2025	The final draft of the IMTP (version 0.3) was submitted to ELT as per the IMTP project timeline.
Reporting to Non-Executive Directors (NEDS)	November & December 2024	November/December 2024 - Board development sessions on IMTP.
	16 January 2025	Finance & Performance Committee (FPC) - update on progress in developing the plan and includes draft IMTP contents page. Meeting minutes note that the draft IMTP was being prepared for presentation to ELT on 12 February 2025 after which it will be circulated to the Board and Committee members by mid-February
	30 January 2025	Trust Board - update on progress and presentation as per FPC (16/01/25) including draft IMTP contents page.
	3 March 2025	ELT reporting (12/02/25) that it was planned to circulate a first draft of the IMTP to Non-Executive Directors (NEDs) week commencing 17/02/25. Email to NEDs (03/03/25) with early draft of IMTP (version 0.2). FPC reporting (18/03/25) noted that this was later than planned and that no comments have been received to date.
	18 March 2025	The IMTP project timeline proposed the final draft of the IMTP to be presented to FPC (18/03/25). We confirmed that version 0.4 of the IMTP was presented along with its appendices (Challenges and Opportunities, Equality Impact Assessment, and Financial Plan) and the endorsement for approval at Trust Board.
	27 March 2025	The IMTP project timeline proposed the final draft of the IMTP to be taken to Trust Board (27/03/25). We confirmed that version 0.5 of the IMTP was presented along with its appendices (Challenges and Opportunities, Equality Impact Assessment, Financial Plan, ministerial templates for timely access, prevention, community capacity, and mental health) and the approval for the IMTP to be submitted to Welsh Government by 31 March 2025.

Appendix B: Assurance Opinion and Prioritisation of Findings

Assurance Opinion

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

Prioritisation of Findings

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

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

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

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

Archwilio Cymru
Audit Wales

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

Date issued: November 2025

Document reference: 4959A2025

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Contents

Audit, Risk, and Assurance Committee update:

About this document

1 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. We presented our detailed 2025 Audit Plan to the committee on 1 May 2025.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Current status
Independent Examination of the 2024-25 Charitable Funds' Financial Statements	Executive Director of Finance and Corporate Resources	The Independent Examination of the Charity's annual report and accounts is due to start in December with the intention of certifying and filing by the Charity Commission deadline of 31 January.

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of Unscheduled Care	Executive Director of Operations	This work examined different aspects of the urgent and emergency care system in three parts: • Part One: Flow out of hospital (not applicable to the Trust). • Part Two: accessing urgent and emergency care. • Part Three: national arrangements and leadership structures.	Part Two: Complete Part Three: Drafting	March 2026.
Structured Assessment deeper dive - Review of	Director of Digital Services	This audit will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the	Drafting.	March 2026.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Digital Transformation		workforce, transform patient care, meet demand, and improve productivity and efficiency.		
Structured Assessment 2025 - core	Board Secretary / Director of Corporate Governance	Our 2025 structured assessment work will review the following areas: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements. This year's work will also include a review of the Trust's arrangements for setting its wellbeing objectives under the Wellbeing of Future Generations (2025) Act.	Complete.	December 2025.
Structured Assessment 2025 – Review of Estates Management	Executive Director of Finance and Corporate Resources	This review will examine the effectiveness of the Trust's corporate arrangements to manage its estate with a particular focus on how it is prioritising resources to meet	Not yet started.	Summer 2026.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		strategic priorities whilst also ensuring the current estate remains fit for purpose.		
Review of Non-Emergency Patient Transport Service	Executive Director of Operations	This review will examine the effectiveness and efficiency of the Trust's Non-Emergency Patient Transport Service, with a particular focus on arrangements for the transfer and discharge function. The specific scope of this work will be determined and discussed with officers in the Trust over the coming months.	Planning.	March 2026.

Other relevant publications

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

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

Title	Publication Date
NHS Finances Data Tool 2024-25	September 2025
Digital Health and Care Wales – Review of Stakeholder Engagement Arrangements	July 2025
Temporary Accommodation, long-term crisis?	July 2025
Cost Savings Arrangements: A Checklist for NHS Board Members	June 2025

Additional information

7 Exhibit 4 provides information on corporate documents recently published by Audit Wales. Links to the documents on our website are provided.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Interim Report 2025-26	November 2025
Estimate of Income and Expenses for the year ended 31 March 2027	November 2025

Title	Publication Date
Equality Report 2024-25	October 2025
Welsh Language Report 2024-25	September 2025

Audit Wales

1 Capital Quarter

Tyndall Street Cardiff, CF10 4BZ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

Structured Assessment 2025

Welsh Ambulance Services University NHS Trust

October 2025

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Contents

Audit snapshot

What we looked at

1 We looked at how well the Welsh Ambulance Services University NHS Trust (the Trust) is governed and whether it makes the best use of its resources. We looked at four areas in particular:

- how well its board works;
- how it keeps track of risks, performance, service quality, and recommendations;
- how it produces key plans and strategies; and
- how it manages its finances.

2 We also looked at the Trust's progress in implementing recommendations from:

- previous structured assessment reports; and
- our 2024 report on cost savings.

Why this is important

3 NHS bodies continue to face a wide range of challenges associated with the need to modernise and transform services to deal with constrained finances, growing demand, treatment backlogs, workforce shortages, and an ageing estate. It is therefore more important than ever for the boards of NHS bodies to have strong corporate and financial governance arrangements in place. This helps provide assurance to themselves, the public, and key stakeholders that they are taking the right steps to deliver safe, high-quality services and to use public money wisely.

What we have found

4 We found that the Trust has an effective Board supported by good governance arrangements. Systems for providing the Board with assurance are effective and are being strengthened through further development of the board assurance framework. A new quality plan is being implemented, but its deliverability is likely to be challenging without dedicated funding. The Trust continues to report challenges to the achievement of key performance targets. Changes to how ambulances responses are measured were introduced during 2025, with a greater focus on patient outcomes. However, it is too early to know what impact the changes are having on service quality.

5 The Trust has a clear and approved Integrated Medium-Term Plan (IMTP) and has recently approved a set of wellbeing objectives. It is also undertaking a timely refresh of its long-term strategy. The Trust has a significant number of change programmes underway, with finite capacity to support them. It is therefore pausing the development of some corporate plans and deferring some planned activities to protect capacity for key priorities.

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

What we recommend

7 We have made four recommendations to the Trust within the following areas:

- Strengthening policy management
- Enhancing reporting of the current board assurance framework;
- Clarifying deliverability of its quality plan; and
- Reporting on any issues with the timely submission of Board and committee papers.

Key facts and figures

- Within the Welsh Government's Escalation and Intervention framework, the Trust is currently at level 1.
- In 2024-25, the Trust met its financial targets by breaking even on both revenue and capital spending.
- In 2024-25, the Trust aimed to save £6.42 million but ended up saving £6.84 million. However, £3.1 million came from staff vacancy savings.
- The Trust's 2024-25 financial statements were submitted for external audit on time, and the Auditor General issued an unqualified audit opinion on 27 June 2025.
- The Welsh Government issued a letter in August 2025 to confirm its approval of the Trust's 2025-28 Integrated Medium-Term Plan.
- Whilst the Trust is facing some unexpected in-year financial challenges, it continues to forecast a breakeven position for 2025-26.
- The Trust has fully implemented the four outstanding structured assessment recommendations since our last report.

Our findings

Board effectiveness and openness

Board and committees operate effectively, reflect on learning, and seek opportunity to continually improve. However, the Trust still needs to address its out-of-date policies

Public openness of board business

8 The Trust continues to conduct its business in a transparent way. The Board holds its public meetings in Cardiff. However, the Trust is exploring ways to rotate meeting locations across Wales to support it in further raising the Board's profile and connect more with staff across the country. Members of the public can send in questions before each meeting for the Board to consider. Our review shows that the Board responds to these questions clearly and effectively. The public can request to observe the Board live or watch the recordings after the meeting via links on the Trust website.

9 Although committee meetings are not broadcast or recorded, the public can still request to attend any public committee meeting. The Trust also routinely publishes Board and committee papers a week before each meeting on its website.

10 The Trust keeps private Board and committee sessions to a minimum, reserving them only for sensitive or confidential matters. After each Board and committee meeting, the Corporate Governance Team quickly publishes an Alert, Assure, Advise paper on the website. This paper highlights the key points discussed. The Trust then uploads the full minutes once they are confirmed at the following meeting.

Supporting effective board conduct

11 The Trust has clear and generally up-to-date governance arrangements that help the Board and its committees run effectively. This includes regular update and review of Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation (SoRD).

12 The Trust reports non-compliance with Standing Orders to the Audit, Risk and Assurance committee. Since the beginning of 2025, there have only been three reported breaches which were on digital procurement, staff payments, and non-approval of minutes. Although Standing Orders state that papers should be submitted at least five days before a Board or committee meeting, the Trust does not currently report any late submissions as a recorded breach of these rules. Whilst the submission of late papers is infrequent, reporting instances to the Audit, Risk Assurance Committee would improve transparency and promote timely submissions.

13 The Trust continues to publish up-to-date declarations of interests and its Register of Gifts and Hospitality on its website. The corporate team continue to raise awareness online and in ambulance stations of the requirement to make gifts and hospitality declarations.

14 In 2023, the Trust reported that only 14% of its policies were up to date. Although we saw improvement in 2024, progress has since slowed. At the current rate, the Trust expects that only 50% of policies will be in date by January 2026.

Board and committee meeting effectiveness

15 The Trust's Board and committees work effectively and are quorate. Their agendas are focussed on risk areas, and work programmes are up to date. The committee structure broadly aligns to the organisation's main goals and risks. To improve this further, the Trust has set up a task and finish group to consider how its committees work and how they could improve. In particular, this group has reflected on the role of the Academic Partnership Committee, now that the Trust has achieved University Trust status.

16 Board and committee meetings are well-run, with agendas focused on the organisation's biggest risks and important issues. Over the past year, key concerns have included growing financial pressures, long delays in handovers, and poor performance in handling complaints and investigations. There is still room for the Board to spend more time on long-term strategy, which is expected to happen as the Trust starts to review its strategic vision and board assurance framework in 2025–26.

17 Board and committee papers are timely and include clear, high-quality information. Presentations are easy to follow and come with cover papers that clearly set out the key issues, recommendations, and actions. Where helpful, the Corporate Governance Team also provides extra background information outside the main agenda through the newly established 'reading room' function which stores additional contextual papers. After meetings, committees continue to share important discussion points and issues with the Board through their Alert, Assure, and Advise Highlight Reports.

18 The Trust is now a named organisation under the Wellbeing of Future Generations Act (2015). It agreed its wellbeing objectives in March 2025 but is still in the early stages of applying sustainable development principles in committee meetings. The Trust recently added these goals to Board and committee cover papers. This should help authors and committees consider how discussions and decisions affect its wellbeing goals.

Hearing from staff and service users

19 The Trust continues to hear direct experiences from staff and patients at the start of meetings. The Quality, Experience and Safety (QuESt) committee hears patient stories and the People and Culture committee hears stories from staff. Stories are also shared at Board meetings, with patient and staff stories shown in turn. In 2024, the Trust has also improved the process for tracking actions and learning following staff stories which now mirrors the process used for patient stories.

20 There are good ongoing approaches for board members to listen to staff. Each month, the Chief Executive leads a 'live' session where staff from across the organisation can speak up and talk about important issues. Board members also meet staff through award events and visits. This includes the Annual General Meeting, staff awards and through the work of the Patient Experience and Community Involvement team. Board members we spoke to felt that they had good mechanisms in place to engage with and hear from staff and patients.

Board cohesion and continuous improvement

21 The Trust's Board has largely been stable during the past 12 months. It changed the Director of People and Culture role in November 2024, splitting the function into two. The Chief Executive Officer left the organisation in June 2025 and following interim arrangements, the new Chief Executive Officer started in October 2025. These changes have been well-managed, with cohesion across the Board evident within our observations and discussions with the Trust. There have been no new Non-Executive Directors in the past year. However, the Trust has joined the aspiring board programme, to develop new independent member expertise for the future.

22 The Board and its committees conduct yearly self-assessments to review how well they are working. the Audit, Risk and Assurance Committee took a new effectiveness approach this year with the aim of improving their committee engagement rates. A smaller sub-group of the Audit, Risk and Assurance Committee met throughout the year to address the numerous questions within the NAO Audit and Risk Assurance Committee Effectiveness Toolkit. At the March 2025 meeting of the committee members reviewed and discussed the feedback. The committee found that the process, whilst resource-intensive, strengthened the quality of feedback and resulted in a number of improvement actions for the committee.

23 The Trust has continued to run its own Board Development Programme during 2024–25. Its bi-monthly sessions were well attended, covering a range of topics. These have included the Wellbeing of Future Generations Act, the duty of quality and candour, and planning for the 2025–28 Integrated Medium Term Plan (IMTP). Board members told us they found the sessions useful.

24 Plans for an externally supported Board Development Programme are ongoing and out to tender during our review. The Trust hopes to have this programme in place by March 2026. Work is also continuing to improve induction programmes for committee members.

Providing board assurance

Recent and ongoing changes to assurance frameworks are supporting improvement, but there is more to do, including a need to ensure its quality plan is achievable within existing resources.

Managing strategic risks

25 The Trust's Risk Management Transformation Programme (2021–24) concluded last year but work to strengthen the board assurance framework (BAF) is ongoing. Previous structured assessments have noted that the BAF has primarily focused on corporate risks, rather than the broader strategic risks linked to the Trust's long-term objectives. This limits its effectiveness in supporting the Board's oversight of risks to strategic delivery.

26 To improve its approach to risk, the Trust commissioned external consultants (BDO Ltd) in early 2024, in part to provide best practice guidance for developing a more strategic BAF. Although the Trust had planned to implement a revised digital version by now, a suitable automated solution has yet to be identified. Although progress had also been limited by resource constraints, the recent appointment of the dedicated Risk Manager is now bringing the capacity needed to bring the risk work back on track. The Trust's plans to begin to update its long-term strategy during 2026-27 may offer a welcome opportunity to align the BAF with the development of potential new strategic objectives.

27 In the meantime, the Trust continues to provide regular oversight of the BAF. The full framework is reviewed by the Board and the Audit and Risk Assurance Committee, while other committees oversee the risks relevant to their areas of responsibility. In addition, the Board has reviewed its six risk appetite statements during board development sessions within the past 12 months.

28 The 2024–25 internal audit of risk management provided a reasonable assurance rating. It found that risk reporting to the Board and committees is effective but highlighted the need for further action once a revised BAF is in place, including updating key documents and delivering staff training.

29 Despite the earlier comment on the need to strengthen oversight of risk to strategic objectives, our review of the BAF found that it provides good coverage of corporate risks and the Trust regularly reviews controls and any gaps in assurance. However, there have been very few changes to risk scores during 2024–25 despite reasonable progress on mitigating actions. This is largely due to the influence of external factors, including handover delays which, whilst improved in recent months, remain high.

30 As the Trust develops a more strategic BAF, there is also an opportunity to enhance the clarity and usefulness of BAF reporting. For example, including a dashboard to track the status of actions and their impact on risk scores could help demonstrate progress more clearly and support more informed oversight.

Managing performance

31 The Trust approved its updated Quality and Performance Management Framework in March 2025. This improves the use of benchmarking, user surveys, consideration of the Trust's statutory duty of quality, and actions to address internal audit recommendations.

32 The Board and its committees regularly and appropriately oversee Trust performance. Each committee also receives reports specific to its responsibilities. The Trust reviews the metrics in its performance report every year to make sure they track progress effectively. In May 2025, Board members said they would prefer fewer, more focused measures that link better to the organisation's strategic goals. They also asked for better data quality and support to help them understand the data. The Trust is now working on these improvements.

33 The Trust has made good progress in rolling out new service models as part of its clinical transformation programme. However, the impact of these changes has not yet been formally reviewed, with a formal evaluation due to begin in autumn 2025.

34 The way that ambulance performance is measured has changed in recent months. The Welsh Government launched a revised Emergency Ambulance Performance Framework as part of a 12-month pilot[1]. The previous call categories of red, amber and green have been altered as described below:

- Purple: People who have had a cardiac or breathing arrest outside of hospital.
- Red: Other life-threatening emergencies, including serious illness or injury where there is a high risk of cardiac or breathing arrest.
- Orange: Urgent cases that need fast ambulance care, following clinical guidelines, and quick transport to hospital or a specialist centre.
- Yellow: Cases that need a clinical assessment. These may lead to hospital transport, referral to a community service, or treatment at the scene.
- Green: Less urgent cases that can be treated at the scene or referred to scheduled services for the right care.

These changes aim to support an increased performance focus on patient outcomes rather than response times. For example, the primary measure for purple calls will be the percentage of people to have a heartbeat restored after a cardiac arrest. As part of the new model, rapid clinical screening will be undertaken for all calls not classified as purple or red to assess the best method of treatment for that patient. At present, it is too early to know what effect this will have on performance. The Trust is currently collating various data to better understand any impact patient outcomes. This is challenging given that outcome data is stored across different Health Board systems across Wales.

[1] Purple and red categories went live from 1 July 2025 and the intention is for the orange, yellow and green categories to go live from 2 December 2025.

35 In addition to changes to performance measures and metrics, the Trust has also seen significant changes to some of its long-standing performance metrics in recent months. Notably, handover delays in June and July 2025 were the lowest they have been in four years, although the picture across Wales is still very variable. The number of patients who cancel their ambulance dispatch has also reduced significantly during the past 12 months. However, whilst performance for some clinical indicators such as return of spontaneous circulation are improving others, such as stroke call to door times, have worsened.

Monitoring quality and safety

36 In May 2025, the Trust launched a new strategic quality plan. The plan focuses on population health, value-based healthcare, and quality management systems. The accompanying implementation plan sets out the actions to deliver the plan over its three-year lifecycle. Whilst the Trust recognises the need to have sufficient staffing and financial resources to deliver the plan, the plan is not supported by any dedicated funding. As a result, achievement of the 121 listed actions to be delivered over three-years, is likely to be very difficult.

37 The Trust has clear accountability for clinical quality governance. The Senior Quality Team oversees delivery of the new strategic quality plan and the Quality Management Group supports the quality management system. However, we have previously highlighted concerns about low attendance at these group meetings. Our review of recent papers shows that attendance remains variable.

38 The QuESt Committee oversees a range of assurances and escalated concerns. These include issues highlighted by the Clinical Quality Governance Group, and through quality metrics in the putting things right report. The Trust has strengthened this report with better data, steps it is taking to meet its legal duty of candour, and organisational learning. The new learning from mortality report, published twice a year, shows that the Trust has a more systematic system in place to review and learn from patient deaths.

39 Although assurance processes have improved, quality metrics show underperformance in some areas. These include delays in responding to complaints, missed audit deadlines, and slow responses to concerns and coroners' reports. Despite the Putting Things Right team growing, there is a backlog of investigations, and both the Public Services Ombudsman and coroners have raised concerns. Almost 80% of learning from events reports are also submitted late. To address these issues, the Trust introduced a recovery action plan in August 2025. However, current capacity constraints may make delivery challenging. The Executive Leadership Team is closely monitoring progress and the Executive Director of Quality and Nursing reports regularly on this to QuESt Committee meetings.

Tracking and monitoring recommendations

40 The Trust is improving its arrangements to track and monitor recommendations. It has worked with Digital Health and Care Wales to build a new automated audit tracking system. Once implemented later in 2025, the Trust will train staff on its use and Audit, Risk and Assurance Committee members will be able to explore progress on recommendations more easily.

41 During the past twelve months, the Audit Risk and Assurance Committee has continued to use the current (Excel based) version of the tracker to track implementation of recommendations. While not being reported at two meetings over the last year, the data shows that the Trust is closing more audit recommendations on time, with fewer deadlines being pushed back. This suggests that the organisation is getting better at setting realistic timelines and following through on audit actions.

42 In 2024, we raised concerns that the Trust was closing some recommendations without enough evidence. However, things have improved. The three recommendations from our 2024 Structured Assessment were completed effectively and within the year. We also understand that the Trust is responding to and closing Internal Audit recommendations appropriately.

Preparing strategies and plans

The Trust has a clear long-term strategy, medium-term plan, and newly agreed wellbeing objectives, however capacity pressures are resulting in some plans being deferred or delayed.

Producing key strategies and plans

43 The Trust's 2018-30 strategy 'Delivering Excellence' appropriately outlines a vision to manage demand differently by changing how it delivers services. It focuses on supporting and treating more people in communities to reduce demand for emergency ambulance services. The Trust intends to refresh its strategy in 2026 and has started events in 2025 to help shape the new version. Following this, it will then develop a new supporting clinical strategy.

44 In 2024, the Trust launched a new clinical model transformation programme to improve how clinical care is delivered. The Trust leads this work, supported by commissioners and partners. The approach aligns to the strategic vision and aims to strengthen clinical support during calls and offer more options for face-to-face care. The Trust has made good progress in rolling out new service models as part of its clinical model transformation programme. It has not reviewed the impact of these changes although we understand a formal evaluation is due to begin in autumn 2025.

45 The Integrated Medium-Term Plan 2025-28 (IMTP) was shaped by internal and external feedback. This included patient stories, staff surveys, and talks with the Joint Commissioning Committee. The Trust also improved its engagement with Non-Executive Directors on the IMTP by holding two board development briefings in November and December 2024. The Finance and Performance Committee then received the full draft on 18 March 2025, prior to Board approval and submission to the Welsh Government. Welsh Government subsequently approved the IMTP. These steps show progress, but there's still room to improve, especially by sharing draft versions earlier, so members have more time to give feedback and inform its development, rather than providing scrutiny to a fully-formed plan.

46 On 30 June 2024, the Trust became one of the specified bodies under the Well-being of Future Generations (Wales) Act. Following this, the Trust has now set its first well-being objectives, based on the sustainable development principle. To help shape the objectives, the Trust, supported by a cross-directorate Task and Finish Group, asked for feedback through social media, Llais, and its citizens panel. However, the engagement only lasted 14 days and not many people responded. Alongside its IMTP 2025-28 the Board approved the Trust's three wellbeing objectives in March 2025, they are:

- a socially responsible and inclusive employer;
- an innovative and sustainable organisation; and
- a pro-active, accessible, and equitable care provider.

47 As an interim approach, the Trust has identified a small number of commitments under each well-being objective, aligned to the Trust's current goals and priorities. This is pragmatic given the Trust's plans update its long-term strategy in 2026. The Trust is also in the process of developing ways to measure progress against its wellbeing objectives which it intends to include in its next Annual Report. The Auditor General will include appropriate work in future years' audit plans at the Trust to assess the progress that is being made, in line with his statutory duties under the Act.

48 The Trust is prioritising the renewal of some plans and extending the life of others. During the past 12 months the Trust has developed a strategic quality plan 2025-28 and a health and wellbeing plan 2025-29. The People and Culture Plan was scheduled for review in 2025. However, the Trust will suggest to the Board that they keep using the current version, as it still meets the organisation's needs.

49 The Trust is managing several major change programmes. This is creating capacity pressures and potential risks. Transformation initiatives such as the clinical model transformation programme, responding to new performance measures, implementing the quality plan, and progressing policy reviews, along with IMTP actions require significant input from across the organisation. Internal Audit has raised concerns about limited capacity to support change and a lack of oversight for some projects. Board and committee discussions show members are aware of these pressures. In response, executive officers have recently held workshops to consider options such as delaying and deferring lower-priority actions within the IMTP.

Board assurance on partnership working

50 The Trust works closely with key partners to support shared goals. It is now part of every Regional Partnership Board (or their sub-groups) across Wales. It works with health boards locally and through national-level Joint Commissioning Committee and Six Goals Programme Board programmes.

51 The Trust reports partnership activities to the Board through IMTP updates, its avoidable harm paper, and CEO and Chair reports. In May, it introduced a new bi-annual engagement report, which gave the Board an overview of key partnership and engagement priorities. Future reports are expected to provide more detail, showing how priorities, such as wellbeing objectives and the new national ambulance performance framework are being put into practice.

Monitoring delivery of strategies/plans

52 The Trust's arrangements for overseeing the delivery of corporate plans are reasonably effective. Each section of the IMTP clearly sets out what the Trust needs to do across the three years of the plan which supports the Strategic Transformation Board in its role of monitoring and reporting progress during the year.

53 The Finance and Performance Committee and the Board continue to challenge and support delivery of corporate plans. Committee scrutiny has led to the Trust strengthening reporting and accountability. This includes clarifying the role of operational groups and strengthening reporting on ministerial priorities using RAG[2] ratings. These changes demonstrate a clear commitment by the to ensure sufficient grip and oversight of plan delivery.

54 The Trust delivered most of its 2024-25 IMTP actions. This included the full rollout of Cymru High Acuity Response Units. The Trust is making reasonable progress in 2025-26, having delivered just over half of the actions planned for the first quarter of the year, but it had to defer a number to later dates due to capacity issues.

[2] Red, Amber and Green

Managing finances

In-year finances are well-managed and there is a reducing reliance on one-off savings. However greater clarity is needed on the affordability of some plans.

Meeting financial objectives and duties

55 The Trust met its financial responsibilities in 2024–25. It recorded a small surplus of £70,000 and broke even over the three-year period from 2022 to 2025. the Trust also spent its capital budget as planned and went beyond the 95% target for complying with the Public Sector Payment Policy.

56 The Trust is showing a revenue deficit for the year so far. However, it still expects to break even by the end of the 2025–26 financial year. At the time of our review, capital spending plans were still being finalised, but the Trust is still forecasting that it will stay within budget this year. It is also on track to meet its targets under the Public Sector Payment Policy.

Financial planning arrangements

57 The Trust's financial planning has supported the achievement of a breakeven position in recent years. The Board approved the Trust's 2025-26 Financial Plan in March 2025 as part of the IMTP approval process, following scrutiny by the Finance and Performance Committee.

58 The financial plan for 2025–26 sets out the main financial risks and challenges. Like other NHS bodies, the Trust's financial plan has little room for unexpected costs or missed savings targets. Some known cost pressures have already materialised, such as the Welsh Government's decision not to fund the rise in employer national insurance. Other pressures, like higher costs from the Welsh Risk Pool were not expected when the Trust developed the plan. The Trust is keeping a close eye on these financial risks and regularly updates the Finance and Performance Committee and the Board on how it is managing them and mitigating a financial deficit at year-end.

59 The Trust has a good record for delivering savings. It overachieved against its 2024-25 overall savings target by £417,000. Positively, it relied less on non-recurrent savings than in previous years as 54% of the savings made in 2024-25 were recurrent. However, of the remaining 46% non-recurrent savings delivered, 97% came from vacant corporate roles.

60 The financial plan for 2025-26 includes an £8.5 million savings target. This equates to 2.7% of the Trust's income. Building on last year's success, the Trust expects 73% of the savings (£6.225 million) to come from recurring schemes that deliver long-term benefits. However, whilst it was over-achieving against its overall savings target at June 2025, its recurring saving schemes are under-delivering. There is again a reliance again on corporate vacancies to achieve the Trust's savings target, which is not a wholly sustainable position.

61 The Trust's financial planning would benefit from clearer costing and affordability checks across all plans, including its strategic quality plan. In addition, Board and committee observations during the year highlighted both ongoing operational pressures and ambitious goals for the Trust's digital services. To support progress, the Trust should show how its plans take account of the resources required, and explain how these will be funded, both through confirmed in-year budgets and commitments for future financial years.

Financial management arrangements

62 The Trust has a good approach to financial management. The Audit, Risk and Assurance Committee and the Board review its Standing Orders and Standing Financial Instructions regularly, most recently in September 2025. Issues of non-compliance are reported to the Audit, Risk and Assurance Committee. The Audit Risk and Assurance Committee also gets regular updates on the Trust's proactive and comprehensive counter-fraud programme of work and reports on high-value purchases, losses, special payments, and single tender actions.

63 However, reports on losses and payments and single tenders, while clear, could be improved by adding comparison charts and accompanying narrative to show and explain changes in volumes and values over time. This would help Audit Risk and Assurance Committee spot trends and outliers more easily.

64 Internal Audit reviewed the Trust's contract management arrangements in June 2025. They found that the Trust needs clearer and more consistent contract management processes. It also needs a way to work out how much time staff need to manage contracts properly, and to formally assign responsibility for this across the organisation. The Trust does not currently have a contract management system. In preparation for the audit, the Trust established a Task and Finish Group to map out existing contracts, though it informed the ARAC that it lacks both the resources and systems needed to maintain the contract register going forward. In responding to the findings of the audit, the Trust has raised awareness of policies and responsibilities for contract management through its staff intranet.

65 The Trust submitted its draft financial statements for 2024–25 on time, as required by Welsh Government. Our audit showed clear improvements in the quality of the accounts compared to the previous year. As a result, only a small number of minor errors were found, and quickly corrected by management. The revised financial statements were reviewed by Audit Risk and Assurance Committee and approved by the Board in meetings on 24 and 26 June 2025, respectively. The Auditor General issued an unqualified (clean) audit opinion on 27 June 2025.

Monitoring financial performance

66 There continues to be strong oversight of financial spending and savings performance. The Trust submits a detailed finance report to each meeting of the Finance and Performance Committee and the Board. The finance report provides a good overview of the current year performance, including a table showing how well recurrent and non-recurrent savings schemes are performing.

67 The Trust has made good progress in responding to recommendations on financial reporting from our Cost Savings Arrangements (2024) and Structured Assessment (2024) reviews. In response, it has strengthened the clarity of its savings and financial performance reporting.

68 Board members demonstrate a clear grasp of the current financial situation and provide a suitable level of scrutiny and challenge to support improvement during committee meetings. In May 2025, the Trust reported to the Audit Risk and Assurance Committee that they are working to develop a new finance dashboard which will further support analysis.

Recommendations

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

Recommendations

R1 To strengthen governance and transparency, the Trust should formally record and report any Board or committee papers submitted after the 5-day publication deadline as a breach of its Standing Orders **(Paragraph 12).**

R2 The Trust should update its policy on policies to make the review process more efficient and practical. This should include clearer steps and methods to convert policies into other types of written control documents (such as procedures or guidelines), where this better reflects their purpose and use(**Paragraph 14**).

R3 To strengthen strategic risk oversight, the Trust should ensure that BAF papers provide a clear, high-level summary of changes to risk scores over time. This should be accompanied by an up-to-date view of associated actions, including their current status and any slippage (**Paragraph 30**).

R4 To ensure the Strategic Quality Plan remains deliverable, the Trust should ensure the assurance provided to QuESt covers the impact of financial and staffing on implementation. This should include updates on whether these constraints are impacting the achievement of planned actions and strategic outcomes (**Paragraph 36**).

Appendices

1 About our work

Scope of the audit

We looked at the following areas for the period May 2025 to September 2025:

- How well the board works.
- How well the board oversees risks, performance, and the quality and safety of services and tracks recommendations.
- How well the body prepares key strategies and plans.
- How well the body manages its finances.

We did not look at the body's operational arrangements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Board conduct its business appropriately, effectively, and transparently?
- Is there a sound corporate approach to managing risks, performance, and the quality and safety of services?
- Is there a sound corporate approach to producing strategic plans and overseeing their delivery?
- Is there a sound corporate approach to financial planning, management, and performance?

Criteria

Our audit questions were shaped by:

- Model Standing Orders, Reservation and Delegation of Powers.
- Model Standing Financial Instructions.

- Relevant Welsh Government health circulars and guidance.
- The Good Governance Guide for NHS Wales Boards (Second Edition).

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Standing Orders and Standing Financial Instructions.
- Key strategies and plans, including the IMTP.
- Key risk management documents, including the board assurance framework.
- Annual Report, including the Annual Governance Statement.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Chair;
- Vice-Chair and Chair of the Charity Committee;
- Chair of Audit, Risk and Assurance Committee;
- Chair of Quality, Experience and Patient Safety Committee;
- Chair of Finance and Performance Committee;
- Chief Executive (June 2025);
- Interim Chief Executive (August 2025);
- Executive Director of Operations;
- Executive Director of Finance and Corporate Resources;
- Executive Director of Quality and Nursing;
- Director of Partnerships and Engagement;
- Director of Corporate Governance/Board Secretary; and

- Director of People.

We observed Board meetings as well as meetings of the following committees:

- Audit, Risk and Assurance Committee;
- Finance and Performance Committee;
- Quality, Experience and Patient Safety Committee; and
- People and Culture Committee.

2 Previous audit recommendations

Outstanding recommendations from previous structured assessment reports

The table below sets out the progress made by the Trust in implementing outstanding recommendations from previous structured assessment reports.

Recommendation	Status
2024 Recommendation 1 The Trust should ensure that Board members are given the opportunity, either within a formal meeting or through circulation outside of meetings, to discuss and scrutinise a draft version of the Integrated Medium-Term Plan ahead of its submission for formal ratification and approval. **Target completion date**: March 2025	Complete (**see paragraph 45**).
2024 Recommendation 2 The Trust should update its Quality and Performance Management Framework to reflect recent changes in key internal roles. **Target completion date**: May 2025	Complete (**see paragraph 31**).

Recommendation	Status
2024 Recommendation 3 The Trust should apply to staff stories the process it has in place for patient stories to provide clarity on how the Trust has recorded the story, how the story has been used for assurance or improvement purposes, and how the Trust has responded to the individual who shared their experience. **Target completion date**: May 2025	Complete. (**see paragraph 19**).
2023 Recommendation 2 Improve quarterly patient experience reporting to QuESt by ensuring a balance of both positive and negative feedback and providing information on what is being done to address the negative themes arising in the report **Target completion date**: September 2023	Complete.

Recommendations from our 2024 Review of Cost Savings Arrangements

The table below sets out the progress made by the Trust in implementing recommendations from our 2024 Review of Cost Savings Arrangements.

Recommendation	Status
2024 Recommendation 1 The Trust should strengthen its approach to identifying and delivering recurrent savings. This will enable it to reduce its reliance on nonrecurrent savings in areas such as vacancy management and place its financial savings plans on a more sustainable footing. **Target completion date**: March 2025	Compete (**see paragraph 59**)
2024 Recommendation 2 The Trust should ensure it takes forward work to address gaps in staff skill sets in respect of the identification and delivery of savings and efficiency opportunities **Target completion date**: June 2025	Complete.

Recommendation	Status
2024 Recommendation 3 The Trust should ensure that its savings reports to Board and F&PC, are consistent or provide a clear explanation of the differences between the reported savings performance. This will aid understanding, reduce confusion, and maintain the credibility of the Trust's savings reporting. **Target completion date**: August 2025	Complete.
2024 Recommendation 4 The Trust should ensure that it fully implements the learning from its recent gateway review of its Financial Sustainability Programme. This will ensure that it further strengthens its savings arrangements and maximises its savings opportunities. **Target completion date**: June 2025	Complete.

3 Key terms in this report

Term	Description
Board assurance framework	A Board assurance framework sets out the risks linked to the organisation's strategic objectives, and the controls and assurances in place to manage those risks.
Clinical Plan	A Clinical Plan is a long-term plan that helps shape how healthcare services are designed and delivered to meet the needs of patients and communities.
Corporate Risk Register	A Corporate Risk Register sets out the organisation's significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.
Counter Fraud	Counter fraud refers to the activity undertaken by the organisation to prevent, detect, and investigate fraud, bribery, and corruption. This work is led by the NHS Counter Fraud Service (CFS) Wales, which operates under the NHS Wales Shared Services Partnership.

Term	Description
Integrated Medium Term Plan	An Integrated Medium-Term Plan 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.
Losses	Losses include things like theft, fraud, overpayments, or damage to property.
Quality Governance	Quality governance is the combination of structures, processes, and behaviours used by an organisation, particularly its board, to lead on and ensure high-quality performance, including safety, effectiveness, and patient experience.
Register of Interests	The Register of Interests helps ensure transparency by recording any personal or business interests of Board members and staff that could influence decisions.
Scheme of Reservation and Delegation	The Scheme of Reservation and Delegation set out which responsibilities stay with the Board and which are passed to committees and executives, along with reporting arrangements to ensure proper oversight.

Term	Description
Single Tender Action	A Single Tender Action is when an organisation buys goods or services from one supplier without going through a competitive process, usually because there is only one suitable option or urgent need.
Special Payments	Special payments are one-off payments made in unusual situations – like compensation or goodwill gestures – that fall outside of the organisation's normal business activity.
Standing Financial Instructions	Standing Financial Instructions set out the financial responsibilities, policies, and procedures adopted by the organisation.
Standing Orders	Standing orders set out the rules and procedures by which the organisation operates and make decisions.
Well-being of Future Generations Act (2015)	This Act requires public bodies in Wales to work sustainably and collaboratively to improve well-being across social, economic, environmental, and cultural areas, by setting long-term goals (called well-being objectives), involving citizens, and making decisions that consider the impact on future generations.

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out his work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

Audit Wales is the umbrella term used for both the Auditor General for Wales and the Wales Audit Office. These are separate legal entities with the distinct roles outlined above. Audit Wales itself is not a legal entity.

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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

Management response form

Audited body	Welsh Ambulance Services University NHS Trust
Audit name	Structured Assessment
Issue date	18 November 2025

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	To strengthen governance and transparency, the Trust should formally record and report any Board or committee papers submitted after the 5-day publication deadline as a breach of its Standing Orders (Paragraph 12).	Accepted. This will be reported by way of a governance report to ARAC from March 2026. Propose closing this action when the reporting is added to the ARAC cycle of business and that cycle approved by the committee.	March 2026	Director of Corporate Governance/Board Secretary
R2	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	Accepted. A policy transformation programme will be scoped out in Q4 of 2025/26. That programme will be	July 2026	Director of Corporate Governance/Board Secretary

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	policies into other types of **written control** documents **(such as** procedures or guidelines**), where this better reflects their purpose and use**(Paragraph 14).	reviewed by ARAC in Q1 2026/27 and overseen by them thereafter. Propose closing this item when that programme has been endorsed by ARAC and implementation and timelines agreed for their continued monitoring.		
R3	To strengthen strategic risk oversight, the Trust should ensure that BAF papers provide a clear, high-level summary of changes to risk scores over time. This should be accompanied by an up-to-date view of associated actions, including their current status and any slippage (Paragraph 30).	Accepted. The summary of changes to risk scores is included in Trust Board papers and will be incorporated into committee papers. Action updates are highlighted in each of the principal risks on the BAF currently, however a section will be added to the risk SBARN to include a high level commentary on the status of actions.	April 2026	Director of Corporate Governance/Board Secretary
R4	To ensure the Strategic Quality Plan remains deliverable, the Trust should ensure the assurance provided to QuESt covers the impact of financial and staffing on	Agreed. Propose that this action is closed after two rounds of reporting into QuEST	July 2026	Executive Director of Quality and Nursing

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	implementation. This should include updates on whether these constraints are impacting the achievement of planned actions and strategic outcomes (Paragraph 36).			

Archwilio Cymru
Audit Wales

Briefing Note

National Fraud Initiative 2024-25: update for Welsh Ambulance Services University NHS Trust

About the National Fraud Initiative

1 The National Fraud Initiative (NFI) is a biennial UK-wide counter-fraud exercise. It helps prevent and detect fraud by electronically sharing and matching data sets. **Appendix 1** provides further information on how the NFI works.

2 In Wales, the NFI operates under the Auditor General's statutory powers. Participation is mandatory for unitary local authorities, NHS bodies, police forces, and fire and rescue authorities. Participating on a voluntary basis in the latest exercise are the Welsh Government, some Welsh Government arm's length bodies (Natural Resources Wales, Arts Council of Wales, Sport Wales, National Library of Wales, Transport for Wales), and South East Wales Corporate Joint Committee.

3 This briefing note provides an update on the latest NFI 2024-25 exercise at a national level and as at 31 July 2025. It also provides some local level data for your organisation, although we are encouraging those charged with governance to seek further local detail from lead officers.

Data submission for 2024-25

4 The NFI 2024-25 exercise is underway. Participants submitted data for the biennial batch data matching exercise in October 2024. This included data on housing benefits, housing tenants and waiting lists, blue badge parking permits, licences, and various payments such as creditor payments, payroll, and pensions.

5 The UK Public Sector Fraud Authority released most data match reports to participants by the end of December 2024. Council tax and electoral register data are submitted annually. The most recent deadline for submitting this data was February 2025.

6 Supplementary data runs take place during the exercise to process new, incomplete or missing data submissions. For example, progress is being made to amend the Public Audit (Wales) Act 2004 through a Legislative Reform Order which will enable the NFI to resume the matching of adult social care data during the NFI 2024-25 exercise.

National update

Data matches and investigation

7 To date, almost 440,000 data matches have been identified for the Welsh NFI 2024-25 exercise participants. **Exhibit 1** shows that most of these matches are for unitary authorities and health bodies.

Exhibit 1: NFI 2024-25 Welsh participant data matches by type of organisation, at end of July 2025

Type of organisation	Number of data matches	% of data matches
Unitary authority	373,114	84.9
Health	50,409	11.5
Police	2,641	0.6
Fire and rescue	740	0.2
Other	12,749	2.9
Total	**439,653**	**100.0**

Source: Audit Wales analysis of NFI web-application data

Note: % total does not match the sum of the parts due to rounding.

8 Data matching identifies potentially fraudulent or erroneous claims and payments. No assumption can be made about whether there is fraud, error, or another explanation until an investigation is carried out. There can, for example, be false positives around creditor payments if bodies are deliberately making staged payments of the same amount.

9 We recognise it is not practical to investigate all data matches, particularly for bodies with large numbers of matches. Bodies are encouraged to take a risk-based approach to assessing data match reports and deciding what type of, and how many, data matches they review.

10 By the end of July 2025, five participating bodies had not yet closed any data matches. Some participants are making good progress with reviewing NFI 2024-25 data matches, while others have made limited progress.

11 **Exhibit 2** shows the total number of data matches for each data match area. It also shows the number of data matches closed in a data match area, along with the number of participants that have matches in that area.

The absence of closed matches indicates that the participant has not reviewed any matches in that area.

Exhibit 2: NFI 2024-25 Welsh participant data matches processed and closed, at end of July 2025

Data match area	Data matches	Data matches closed	Participants with data matches	Participants with no closed statuses for their matches
Council tax single person discount	198,146	5,385	22	11
Creditors	187,228	19,791	48	16
Council tax reduction scheme	16,578	3,547	22	1
Blue badges	10,377	5,849	22	3
Payroll	8,150	1,705	46	6
Housing waiting lists	6,359	1,392	18	5
Housing tenants	4,636	879	11	2
Pensions	2,962	1,098	12	4
Resident parking	2,405	2,368	8	1
Procurement	1,985	400	42	28
Housing benefit	826	483	22	2
Taxi drivers	1	1	1	0
Total	**439,653**	**42,898**	**49**	**5**

Source: Audit Wales analysis of NFI web-application data

Note: After risk assessing data match reports and any subsequent investigations, each data match should be ‘closed’ and given a match status. There are a range of ‘closed’ statuses. Matches not investigated should be given the status ‘Closed – Not selected for investigation’. Assigning match statuses to data matches can be done individually or by bulk selection.

Outcomes

12 Welsh participants recorded outcomes of £4.7 million for the period 1 April 2024 to 31 July 2025. **Exhibit 3** shows which matching process the outcomes relate to.

Exhibit 3: Welsh participant reported NFI outcomes, 1 April 2024 to 31 July 2025

NFI exercise	Outcomes (£s)
NFI 2024-25 biennial exercise	1,719,037
Late savings from the NFI 2022-23 biennial exercise	867,157
Annual council tax data matching exercises	2,080,831
Total	**4,667,025**

Source: Audit Wales analysis of NFI web-application data

Note: Outcomes are made up of (i) actual amounts participants have recorded as fraud or error; and (ii) estimated elements which seek to capture the value of loss from a fraud or error detected, and the value of any future losses that bodies may have incurred without intervention following an NFI match. Most datasets have a methodology to calculate estimated savings. All methodologies are reviewed by the Cabinet Office's NFI Governance Board and approved by the Cabinet Office's Fraud Prevention Panel.

Local update

13 Data matches are released in data match reports. Each report has a different purpose and compares data from two or more datasets. The reports are broken down into dataset types: for example, housing benefit, payroll, or creditors.

14 An organisation's risk assessment of the data match reports should determine the types and numbers of data matches to be investigated. To aid risk assessment, the NFI web application flags some data match reports as 'key reports' with historically high success rates in identifying fraud or error. Also, most individual data matches are assigned a fraud risk score.

15 **Exhibit 4** shows the total number of data matches identified for Welsh Ambulance Services University NHS Trust, along with those recorded in key reports. **Appendix 2** provides some further analysis of these data matches by fraud risk score.

Exhibit 4: Welsh Ambulance Services University NHS Trust's NFI 2024-25 data matches, at end of July 2025

Data match area	Data matches in all reports	Data matches in key reports with historically high success rates
Creditors	1,578	1,050
Payroll	80	45
Procurement	3	3
Total	**1,661**	**1,098**

Source: Audit Wales analysis of NFI web-application data

Note: Council tax single person discount data match reports are not formally designated as 'key reports' but are treated as such in practice.

16 Various factors can influence which data match reports are reviewed and when this takes place. For example, an organisation may prioritise looking at data match reports linked to areas where it has concerns about internal controls or where there is a history of fraud or error. Also, local resourcing will dictate the pace of progress. For these reasons, this general update does not provide further detail on where processing work and outcomes are recorded by your organisation at this stage.

17 The NFI web application features a dashboard and provides various reports on outcomes and processing activity. We encourage those charged with governance to seek more detailed updates on processing work and outcomes recorded from their NFI Senior Responsible Officer and NFI Key Contact.

Future Audit Wales work

18 For this NFI exercise we will carry out a high-level assessment of participants' governance and follow-up arrangements. We will engage with bodies over the autumn/early winter to consider issues covered in our NFI self-appraisal checklist.[1] We will also analyse the risk assessment and data match processing work carried out, and the outcomes recorded by participants, as reflected in the NFI web application.

19 This work will help us understand the factors influencing the outcomes reported by individual bodies and the variations between them. Findings from this assessment will inform our next national report in autumn 2026.

[1] In December 2024, we shared the updated checklist with NFI senior responsible officers and key contacts. We encouraged all bodies to complete it and share it with those charged with governance.

Appendix 1 – The National Fraud Initiative

The NFI uses data matching to detect and prevent fraud. It electronically compares sets of data against other records held by the same and other bodies, to see to what extent they match.

The data matching flags anomalies or inconsistencies that indicate potential fraud or error. Indicators of potential fraud are reported to the participants, who are responsible for following up these matches.

The effectiveness of the NFI depends on the thoroughness of the assessment and investigation of matches and recording of outcomes.

Bodies record the outcomes in the NFI web application. Each participant body has a nominated Senior Responsible Owner and Key Contact for the NFI, who in some cases may be the same individual.

The UK Public Sector Fraud Authority, part of the UK Government's Cabinet Office and HM Treasury, oversees the NFI across the UK. Audit Wales leads the exercise in Wales under the Auditor General's powers in the Public Audit (Wales) Act 2004. The Auditor General's Code of Data Matching Practice summarises the key legislation, and controls, governing the exercise in Wales.

We published a report on the outcomes from the 2022-23 NFI exercise in October 2024. Reports on the NFI for other parts of the UK are produced by the Public Sector Fraud Authority, Audit Scotland, and the Northern Ireland Audit Office.

There is no direct cost to participants for taking part in the exercise. Audit Wales receives funding, through the Welsh Consolidated Fund, to pay for bodies to participate in the NFI. This covers the central data matching processing for the biennial exercise, as well as the annual exercise for council tax and electoral register datasets. This remained the case for the NFI 2024-25 exercise. The main costs to participants are, therefore, the resources used to submit data and conduct follow-up work once data matches are released.

Appendix 2 – Analysis of data matches by fraud risk score for Welsh Ambulance Services University NHS Trust

The NFI assigns a fraud risk score of very high risk, high risk, or medium risk to most, but not all, data matches. This risk score is based on a combination of two factors:

- Risk logic – a set of criteria for each dataset combination that, when met, indicates a fraudulent outcome is more likely to occur.
- Footprint score – the number of times an individual in a match appears at the address across all NFI data. It is an indicator of whether that person resides at that address.

Exhibit 5 and **Exhibit 6** provide further analysis of Welsh Ambulance Services University NHS Trust's data matches by risk score for data matches in all data match reports and those in key reports. This analysis builds on **Exhibit 4** in the main body of this briefing note. Not all data matches are formally assigned a risk score. Council tax single person discount data matches and matches in key reports that are not formally assigned a risk score should generally be treated as 'very high risk' in practice.

Exhibit 5:Welsh Ambulance Services University NHS Trust's NFI 2024-25 data matches by risk score for data matches in all reports, at end of July 2025

Data match area	All data matches	Very high risk	High risk	Medium risk	No risk score
Creditors	1,578	212	1,366	0	0
Payroll	80	7	36	28	9
Procurement	3	0	0	0	3
Total	**1,661**	**219**	**1,402**	**28**	**12**

Source: Audit Wales analysis of NFI web-application data

Exhibit 6: Welsh Ambulance Services University NHS Trust's NFI 2024-25 data matches by risk score for data matches in key reports, at end of July 2025

Data match area	All data matches	Very high risk	High risk	Medium risk	No risk score
Creditors	1,050	181	869	0	0
Payroll	45	7	8	21	9
Procurement	3	0	0	0	3
Total number of data matches	**1,098**	**188**	**877**	**21**	**12**

Source: Audit Wales analysis of NFI web-application data

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

Agenda Item No.	07

REPORT TITLE

2025/26 Quality Governance Reviews

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	2 December 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The approach to the 2025 quality and governance reviews, previously referred to as effectiveness reviews, was revised following this committee's endorsement of a programme of work to explore opportunities for further efficiencies within the board's governance framework.

2. To support this, a sub-group of the Audit, Risks and Assurance Committee (ARAC) has been established to oversee the review. The focus of the review was on reassessing the distribution of delegated responsibilities across the board's committees, with the aim of improving efficiency and effectiveness. This work responds directly to findings from the 2024/25 reviews, particularly those relating to Non-Executive Director (NED) availability, quorum challenges, the volume of meetings, and the transitional status of the Academic Partnerships Committee (APC).

3. The sub-group met three times. The review was driven by key project objectives:

   - Aligning committee remits more closely to the six strategic objectives
   - Improving efficiency and effectiveness in governance
   - Reducing meeting frequency and alleviating quorum/NED availability pressures
   - Ensuring strong scrutiny, challenge, and support through increased NED attendance on key committees
   - Balancing workloads and minimising disruption during a period of executive transition

4. A number of options were considered, with the preferred option to reduce the number of committees from seven to six, with each committee having four NEDs and a quorum of three. It recommends that the Academic Partnership Committee (APC) is disbanded, redistributing its functions (research, innovation, partnerships) to the Finance and Performance Committee (FPC) and the People and Culture Committee (PCC). Remit adjustments will be made to ARAC (resilience, cyber, information governance). This option meets the project's objectives, including improved NED attendance, reduced meeting frequency, and better alignment to strategic objectives.

5. The Board will be starting a development and effectiveness programme with an external provider in Q4, running into Q1 2026/27 and part of their scope will be a review of committee responsibilities and structures, therefore making major changes before that work is completed would be premature. Therefore, to allow this work to progress and potentially provide alternative structures/approaches, it is proposed that full implementation of Option 1 – particularly the major changes affecting FPC and ARAC and increasing NED membership – is deferred. Timing of this will depend on the outputs of the review but could take place in mid-2026/27.

6. Notwithstanding the broader work on committee structures, four of the seven board committees undertake reviews of their effectiveness in October and November. APC, the Quality, Patient Experience and Safety Committee (QuEST), PCC and FPC all reviewed their terms of reference and made minor amendments, which this committee is requested to endorse for board approval.

7. Approaches for the 2025/26 quality and governance reviews for ARAC and the board are proposed in this paper and align to the approach in 2024/25.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to:

1. Note the issues considered with respect to the wider board committee framework changes and endorse option 1, to be deferred until the outcomes of the externally facilitated board effectiveness review are received and considered (noting this may be mid-year in 2026/27).

2. Endorse the changes to the terms of reference of the Quality, Patient Experience and Safety Committee, People and Culture Committee, and the Finance and Performance Committee, and recommend their approval by the Trust Board in January 2026.

3. Approve the approach to the quality and effectiveness review for ARAC, being that the ARAC sub-group will review the NAO effectiveness toolkit and provide this and any key issues to the March 2026 meeting, alongside responses to a short qualitative survey of members.

4. Recommend to the board that their quality and governance review includes a repeat of the survey conducted in 2024/25.

ADDITIONAL PAPER(S)

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

Annex 1 – Proposed amendments to the QUEST Committee's terms of reference

Annex 2 – Proposed amendments to the People & Culture Committee's terms of reference

Annex 3 – Proposed amendments to the Finance & Performance Committee's terms of reference

Annex 4 – Trust Board quality and governance questionnaire

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
As noted in the SBARN

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
16 July and 24 September	ELT discussions on 2025-26 reviews
25 July and 30 September	ARAC Sub-Group discussions on 2025-26 reviews
2 September 2025	ARAC update on quality and governance review
7 October 2025	APC meeting re quality and governance review
4 November 2025	QuEST meeting re quality and governance review
13 November 2025	PCC meeting re quality and governance review
18 November 2025	FPC meeting re quality and governance review

SITUATION

1. This paper seeks the committee's endorsement of proposed changes to the board's committee framework. These follow the briefing provided to this committee on 2 September. While some changes will be deferred, others have already been actioned and endorsed by the relevant board committees.

2. Attached are the updated terms of reference for the Academic Partnership Committee (APC), the Quality, Patient Experience and Safety Committee (QuEST), the People and Culture Committee (PCC), and the Finance and Performance Committee (FPC). These are presented for endorsement following their recent quality and governance reviews (formerly known as effectiveness reviews) for 2025/26.

3. The proposed approaches for the quality and governance review of this committee and the board are also set out for approval.

BACKGROUND

4. Following the 2024/25 committee quality and governance reviews, the Audit, Risk and Assurance Committee (ARAC) identified opportunities to further streamline the Trust's governance structure. A project plan was initiated with the aim of ascertaining if the endorsed spread of board responsibilities could be redistributed in a way that is more efficient and effective. A sub-group of ARAC was formed to support this work and included the Non-Executive Directors (NEDs) of ARAC, Chris Turley and Trish Mills.

5. As indicated at the September ARAC meeting, the project took account of the key concerns raised during the 2024/25 reviews which included NED availability and consequent quorum pressures, the transitional status of the APC post-university Trust status, and the high volume of meetings (52 ordinary meetings a year).

6. The review aimed to align committees wherever possible to our six strategic objectives, so they are best placed to drive progress, monitor outcomes and performance, and to respond to emerging priorities.

7. An update on this work was provided to APC, QuEST, PCC and FPC during October and November, with the views of those members forming the latest iteration of this review. Those committees (other than APC) also undertook their quality and governance reviews at that time and endorsed changes to their terms of reference.

ASSESSMENT

The Board's Committee Framework

8. From July to September the Executive Leadership Team (ELT) and the ARAC sub-group considered a number of issues and options, some of which fully met the objectives of the project and others that only partially met the scope. These included:

8.1. **Option 1** - reduce the number of committees from seven to six. Each committee would have four NEDs in the members and a quorum of three. The APC would be disbanded. Its functions relating to research, innovation, and commercial partnerships would move to FPC, while its responsibilities for education partnerships and collaboration would move to PCC. To balance the extra responsibilities transferred to FPC, the areas of resilience, cyber security, and information governance (mainly internal controls) would transfer from FPC to this committee.

There would be no change to the Charity Committee or Remuneration Committee.

This option meets the vision of the project, including reduction in frequency (4 x APC meetings), desired NED attendance at four for each meeting and alignment to strategic objectives.

8.2. **Option 2** - as above but reduce frequency of FPC to quarterly with flexibility for short and focused stand-alone meetings for items such as the IMTP and budget approvals where necessary.

Whilst this meets the vision of the project in both desired NED attendance and reduction in frequency (2 x APC and 2 x FPC meetings), concerns have been raised as to financial oversight and optics thereof in a challenging financial environment of reducing the FPC meetings.

While not a preferred option at this point, it is one to keep under review, particularly in light of the fact that other major committees focused on areas such as quality, patient safety, and people currently meet quarterly.

8.3. **Option 3**: No reduction in committees, but a change to the name and remit of APC, which could become a committee focused on research, innovation, commercial development and technology.

The advantage of this option is that it would provide dedicated focus on these important areas and a stand-alone Committee aligned to SO3 and parts of SO4. However, it would not achieve the goal of reducing meeting frequency or increasing NED attendance. Additionally, we could face the same challenge as with the current APC i.e. limited agenda content due to the current maturity of these areas at WAST. It would also decouple commercial from financial discussions and potentially financial sustainability. This may therefore be better considered as a future option as these areas mature.

The ELT was keen that this was an option to be revisited in the future, when the strategic links with these areas mature further.

8.4. **Option 4** included APC being disbanded but material changes being made to remits between FPC and ARAC, moving the latter into capital and revenue strategy and monitoring; business cases; and infrastructure.

Whilst this option meets the vision of the project in terms of reduction in frequency (APC and FPC in particular – reduction of six meetings), desired NED attendance at four for each meeting, however is less squarely aligned to SOs.

It would see ARAC moving into more performance-based work, which is at odds with the HFMA audit committee handbook and Audit Wales' expectations of audit committee functions. It also will give ARAC oversight of a strategic objective (SO6 delivering exceptional value) which could impede their independence more generally on the strategic delivery frameworks, risk and internal controls.

9. The ARAC sub-group also discussed and considered a number of issues including: potential role conflicts, cross-committee connections, and changing board dynamics and skills mix. Further work will be undertaken in this area, particularly in collaboration with externally appointed facilitators (see further below).

10. Timing of this will depend on the outputs of the review but could take place in mid-2026/27.Further discussions have been held with the NEDs and the Trust Board Chair on NED availability to undertake further committee roles given their current commitments and contractual arrangements with Welsh Government. These commitments include board and committee meetings (including chairing), preparation for meetings, board development days (six per year), mandatory training, board visits to triangulate assurance and meet our people, attendance at

long service awards, CEO roadshows etc., establishing relationships with executives and taking on board champion roles.

11. Taking account of the above, option 1 was favoured by the ELT and the ARAC sub-group as it meets the project's objectives, including increased NED attendance, reduced meeting frequency, and better alignment to strategic objectives.

12. The Board will be starting a development and effectiveness programme with an external provider in Q4, running into Q1 2026/27. The programme will review whether the current number and scope of committees are right for an organisation of WAST's size and complexity. It will also look at whether the Board's focus, timing, and balance between strategy, performance, risk management, and culture are appropriate. The findings from this review (expected in Q1) are likely to influence both the remit and meeting frequency of some committees, especially FPC, where there is currently significant overlap with work going to the Board. This may lead to further changes to terms of reference mid-year. Therefore, it is proposed that full implementation of Option 1 (particularly the major changes affecting FPC and ARAC and increasing NED attendance) is deferred. Timing of this will depend on the outputs of the review but could take place in mid-2026/27.

13. In light of this, The ARAC sub-groups has recommended that this committee endorse the following changes to the Board's committee framework to take effect from 1 April 2026, with any material changes deferred until the outcomes from the external review has been considered:

    - APC will continue to meet twice annually in 2026/27, with a focus on the research and development portfolio. This was agreed at the APC meeting in October and is reflected in their terms of reference.
    - APC delegated responsibilities relating to education partnerships and collaboration will transfer to PCC and those related to commercialisation will transfer to FPC. This was agreed at the PCC and FPC meetings in November and is reflected in their terms of reference
    - Minor changes are proposed for the Quality, Patient Safety and Experience Committee (QuEST) with the transfer of value based healthcare from FPC. This was agreed at the QuEST meeting in November and is reflected in their terms of reference.
    - No changes are proposed for the Charity or Remuneration Committees.
    - Membership and Quorum will be maintained as it is currently with most committees having three members and a quorum of two. The terms of

reference recognise that where there may only be two NEDs in a meeting due to sickness or absence is sub-optimal, but where absences are known in advance other NEDs will be co-opted in.

14. Where further changes to the committee framework and remits are recommended following the externally facilitated review this will come back to ARAC. This may mean a return to this issue in mid-2026/27.

Quality and Governance Reviews for QuEST, PCC and FPC

15. In parallel with the work on the wider committee structures, each committee is required to complete an annual effectiveness review. Members will recall that the 2024/25 quality and governance reviews were comprehensive, involving a detailed examination of the terms of reference and the assurance reporting arrangements for each delegated responsibility for each committee. These reviews led to several changes to the terms of reference.

16. Given the extensive review undertaken in 2024/25, ARAC agreed that this year's approach would be qualitative. For QuEST, PCC and FPC a survey of members was carried out to gather feedback on the proposed changes to the terms of reference (including membership) and to identify what is working well and where improvements could be made. The following four questions were asked:

- Are there any changes you wish to see to the terms of reference
- Are there any changes you would like to see to the committee's membership
- What works well in this committee
- What improvements would you recommend

17. Engagement in the surveys was not high; however, a good deal of qualitative information was obtained. There is nothing to escalate from any of the committees in the responses. The committee annual reports and cycles of business are being drafted for their next meetings, and these will come through to this committee as required under the Standing Orders.

18. The changes agreed to the committee's terms of reference are marked up at Annexes 1-3. ARAC is asked to endorse these changes and recommend their approval to the board.

19. The quality and governance review for the Remuneration Committee, Charity Committee and APC will take place in December, January and March respectively.

Quality and Governance Reviews for ARAC and the Board

20. ARAC undertakes its annual quality and governance review in line with the National Audit Office (NAO) effectiveness toolkit. Members will recall this is an extensive questionnaire.

21. In 2024 this committee agreed that the most effective way to approach the toolkit was for the ARAC sub-group to proactively address the questionnaire by identifying and addressing any gaps in advance. This preliminary work streamlined the review by allowing the committee to focus on key areas of improvement and maintain continuous oversight of their responsibilities.

22. It is proposed that this approach is repeated for the 2025/26 quality and governance review. During the next meeting members will have the opportunity to confirm and challenge the pre-completed questionnaire and discuss any areas identified by the sub-group.

23. In addition to this, it is proposed that the same survey is conducted with ARAC based on the questions in paragraph 16 above.

24. With respect to the quality and governance review for the board, it is proposed that the survey conducted last year is repeated to illustrate areas that may have improved or where further improvements are required. The survey questions are at Annex 4.

25. Alternatively, members may wish to relay on the various diagnostics and surveys that the external facilitators will roll out in Q4, however the outputs of those reviews may not be finalised by May 2026, which is when we usually report on the board's effectiveness publicly. Survey fatigue is a consideration here given the multiple surveys already distributed for committees and the low response rates.

RECOMMENDATION

26. The recommendation is as set out in the front cover above.

NEXT STEPS

27. Quality and governance reviews for the Remuneration Committee (4 December). Charity Committee (13 January) and APC (March 2026).

28. Kick off meeting with external facilitators on 28 November 2025.

29. January 2026 board meeting to approve the terms of reference for APC, QuEST, PCC and FPC.

30. Annual reports for APC, QuEST, PCC and FPC to be presented in January and February 2026

31. Sub-Group to meet to complete the NAO toolkit.

32. ARAC meeting in March to undertake their quality and governance review, review their terms of reference and changes to terms of reference.

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2025/26~~2026-27

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

1.2. In line with Standing Orders, the Board shall nominate annually a Committee to be known as the Quality, Patient Experience and Safety Committee. This Committee has a key assurance role on behalf of the Board in relation to the Trust compliance with the Commissioning Core Quality Requirements, the NHS Wales Health & Care Quality Standards 2023 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3. The Committee plays an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions.

2. PURPOSE

2.1. The Committee is responsible for scrutinising improvements in outcomes in quality, patient experience, effectiveness, and safety to reduce incidences of avoidable harm.

2.2. The Committee will provide oversight of, and seek assurance on, statutory and regulatory compliance on areas within its remit.

2.3. The Committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.4. The Committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the Committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

2.5. In alignment with the Wellbeing of Future Generations (Wales) Act 2015, this Committee will adopt a long-term perspective in its deliberations and decisions. The Committee will consider the broader implications of its actions, particularly in relation to the three wellbeing objectives established by the trust in order to contribute positively to the wellbeing of future generations. These objectives are: 1) being a socially responsible and inclusive employer, 2) fostering an innovative and sustainable organization, and 3) ensuring we are a proactive, accessible, and equitable care provider.

3. DELEGATED RESPONSIBILITY

The Committee will:

Strategic Development and Delivery

3.1. Oversee and contribute to the development of the Trust's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.

3.2. Consider the implications for quality, safety and equitable care in strategies and aligned plans.

3.3. Receive assurance on the implementation of strategies and plans within the remit of the Committee, with a particular focus on the impact of desired outcomes in those strategies and plans.

Safe Care, Equitable Care

3.4. Receive assurance on compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to improve the quality of healthcare provided by the Trust and to support the delivery of an open and honest reporting and continuous learning culture.

3.5. Receive assurance that the Health and Care Quality Standards 2023 are embedded Trust wide with actions taken in relation to any identified non-compliance.

3.6. Receive assurance that there is a quality management system in place that ensures compliance with relevant standards and regulations, facilitates continuous improvements and processes, and enhances patient safety and patient experience.

3.7. Receive assurance that there is a process in place for quality impact assessments. Consider the implications for quality and safety and equitable care arising from the development of the Trust's corporate strategies and plans, or those of its stakeholders and partners, including those arising from any Committees of the Board.

3.8. Receive reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality safety, effectiveness and patient experience and seek assurance of the actions being taken by management to address these.

3.9. Receive assurance that the Trust is compliant with the Dementia Standards, Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005.

3.10. Review the annual infection prevention and control plan and receive assurance on its implementation and the systems in place to ensure compliance with statutory and regulatory requirements for infection prevention and control.

3.11. Receive assurance that the Trust is meeting its obligations with respect to safeguarding of children and vulnerable adults.

3.12. Review the impact of professional standards and staffing issues on patient care, noting the People and Culture Committee has oversight of the selection, training, registration, and revalidation for staff.

3.13. Ensure that robust arrangements are in place for the review of patient safety incidents (to include near misses) to identify similarities or trends and areas for focused or organisation-wide learning.

3.14. Review and recommend to the Board the Trust's annual Duty of Candor and Quality Report(s) and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety.

3.15. Review policies in its remit and endorse policies for Board approval that relate to complaints and incidents in line with Putting Things Right.

Effective, Timely

3.16. Receive assurance that the care planned and provided across the breadth of the organisation's functions is evidence-based, clinically effective and quality driven and where this falls beneath expected standards, the impact is reviewed to support continuous improvement.

3.17. Approve the Trust's clinical audit plan that meets the standards set for the NHS in Wales; review the outcomes of clinical audits in line with the clinical audit plan and provide assurance to the Audit, Risk and Assurance Committee in this respect.

3.18. Advise the Board on a set of key indicators for quality, patient experience and clinical safety, and monitor performance against those indicators.

3.19. Receive assurance that there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation.

~~3.19.~~3.20. Receive assurance on delivery of core aims in relation to delivering value and development of value based healthcare in an out of hospital setting.

Patient Centred

~~3.20.~~3.21. Oversight of patient experience feedback, including themes, trends and learning, and approve the Patient Experience Plan on behalf of the Board.

~~3.21.~~3.22. Receive assurance that the organisation has a patient centred approach, putting patients, patient safety, quality of care and safeguarding above all other considerations.

~~3.22.~~3.23. Receive assurance that the Patient Experience & Community Involvement (PECI) continuous engagement model is taken into account in the design and delivery of services, ensuring the full implementation of lessons learnt.

~~3.23.~~3.24. Receive assurance that lessons are learned from patient experience information and patient safety and workforce related incidents, complaints, and claims, and that learning from reports and incidents is embedded in the Trust's practices, policies and procedures.

~~3.24.~~3.25. Receive assurance that there is good collaborative team and partnership working to provide the best possible outcomes for its citizens.

~~3.25.~~3.26. Ensure any matters raised by the Executive Director of Quality & Nursing (including in their role as Caldicott Guardian), Executive Director of Paramedicine, or other Directors in relation to patient safety and clinical risk are considered and addressed promptly and fully.

Risk and Audit

~~3.26.~~3.27. Oversee the effective management of strategic and principal risks, as set out within the Board Assurance Framework (BAF), as appropriate to the purpose of the Committee.

~~3.27.~~3.28. Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities, and that these are compliant with relevant legislation.

~~3.28.~~3.29. Receive and gain assurance from internal and external audits in their remit. The Committee will receive assurance that management actions to address recommendations are in place via the audit tracker and receive appropriate reporting as agreed by the Audit, Risk and Assurance Committee. This Committee will, where appropriate, scrutinise the impact of actions in response to audit recommendations.

4. AUTHORITY

4.1. The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

4.2. The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

4.3. The Committee is authorised to approve Trust wide policies other than those policies reserved to the Board ~~in accordance with the policy for the Review, Development and Approval of Policies~~.

4.4. The Committee is authorised to approve the annual clinical audit plan.

Chair's Action

4.5. There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies

particularly given the current backlog.

4.6. In these circumstances, the Chair and the Lead Executive, supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

4.7. The Director of Corporate Governance/Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Sub-Committees

4.8. The Committee may establish sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-Committees may only be established with the agreement of the Board.

5. MEMBERSHIP AND QUORUM

5.1. The Trust's Standing Orders at 3.3.5 and 3.3.6 provide the rules around Committee membership. That includes that the designation of Chair, definition of member roles and powers, and terms and conditions of appointment are determined by the Board, based on the recommendation of the Trust Chair. Executive Directors and other Trust officers cannot be appointed as Committee Chairs, nor should they be appointed to serve as 'members' on any Committee set up to review the exercise of functions delegated to them. They may however be 'in attendance' as appropriate.

5.2. The application of these provisions means that the designation of 'members' in NHS Wales Committees is applied to Non-Executive Directors. This ensures there is independent scrutiny, support and challenge, and is a relevant for quorum (see below) and – where it is required – for voting

5.3. Notwithstanding the above, the 'members' and 'prescribed attendees' listed below are often referred to collectively as members or membership.

Committee Membership

5.4. The Committee will comprise three Non-Executive Directors, one of whom will

be designated as Chair, and the following prescribed attendees:

- Executive Director of Quality and Nursing (Committee Lead)
- Executive Director of Paramedicine
- Executive Director of Operations
- Executive Director of Strategy, Planning and Performance
- Director of Digital Services
- Trade Union Partners (x 3)
- Chairs of Sub-Committees (where established)
- Director of Corporate Governance/Board Secretary

5.5. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

5.6. Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Director of Corporate Governance/Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

5.7. The Chair of the Trust Board and the Chief Executive have a standing invitation to attend meetings. In addition, the Committee Chair may invite others (either Trust staff or persons outside the Trust) to attend all or part of the meeting to assist with its discussions on any particular matter. The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge, and expertise

Quorum

5.8. The quorum for meetings of the Committee shall be two Non-Executive Directors.

5.9. While only two Non-Executive Directors are required for quorum, it is strongly recommended that all three Non-Executive Director members be present at each meeting to ensure robust discussion and effective oversight. The presence of all Non-Executive Directors is crucial for fostering diverse perspectives and maintaining rigorous challenge and scrutiny. Therefore, other Non-Executive Directors of the Board may be co-opted to meetings where it is not possible for all three Non-Executive Directors to attend

Member Appointments

5.10. The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the Committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

5.11. Non-Executive Directors shall be appointed to hold office for a period of one year at a time, (membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

5.12. Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

6. COMMITTEE MEETINGS

Secretariat and Support to Committee Members

6.1. The Director of Corporate Governance/Board Secretary, on behalf of the Committee Chair, shall:

(a) arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
(b) ensure the provision of a programme of organisational development for Committee members, as part of the Trust's overall Board development programme.

Frequency of Meetings

6.2. Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board business. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

Withdrawal of individuals in attendance

6.3. The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

7. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

7.2. The Committee, through its Chair and members, shall work closely with the Board's other Committees and groups to provide advice and assurance to the Board through the:

(a) joint planning and co-ordination of Board and Committee business; and

(b) sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.

7.3. The Committee will consider the assurance provided through the work of the Board's other Committees and sub-groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

7.4. The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1. The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes a written highlight report, the submission of Committee minutes and written reports where appropriate throughout the year;

(b) bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

8.2. The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1. The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 6)

10. REVIEW

10.1. These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

PEOPLE AND CULTURE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2025/26~~2026/27

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the board's behalf or to provide advice and assurance to the board in the exercise of its functions. The board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2. In line with Standing Orders, the board shall nominate annually a committee to be known as the People and Culture Committee. The detailed terms of reference and operating arrangements set by the board in respect of this committee are set out below.

1.3. The committee plays an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the board's behalf; and
- providing a forum where ideas can be explored in greater detail than board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the board on the issues within the committee's remit allow for more focused discussions.

2. PURPOSE

2.1. The purpose of the People and Culture Committee ('the committee') is to enable scrutiny and review of the Trust's arrangements for all matters pertaining to its workforce, both paid and volunteer, and organisational culture and behaviour to a level of depth and detail not possible in Board meetings. The Committee will provide assurance to the Board of the Trust's leadership arrangements; behaviours and culture; training, education and development; equality, diversity and inclusion; health, safety and welfare; people and culture related partnerships and engagement; the Welsh Ambulance Services Partnership Team (advisory group); and Welsh Language, in accordance with its stated objectives and the requirements and standards determined by the Welsh Government, the NHS in Wales and other regulatory bodies.

2.2. The Committee will provide evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to all matters relating to staff and staffing of the Trust.

2.3. The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.4. The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

2.5. In alignment with the Wellbeing of Future Generations (Wales) Act 2015, this committee will adopt a long-term perspective in its deliberations and decisions. The committee will consider the broader implications of its actions,

particularly in relation to the three wellbeing objectives established by the trust in order to contribute positively to the wellbeing of future generations. These objectives are: 1) being a socially responsible and inclusive employer, 2) fostering an innovative and sustainable organization, and 3) ensuring we are a proactive, accessible, and equitable care provider.

3. DELEGATED RESPONSIBILITY

The Committee will, in respect of its role in providing advice and assurance to the Board:

Strategic Development and Delivery

3.1. Oversee and contribute to the development of the Trust's strategies and plans as they relate to people and culture and ensure they are aligned to the 2030 Delivering Excellence Long Term Plan.

3.2. Receive assurance on the implementation of strategies and plans within the remit of the committee, with a particular focus on the impact of desired outcomes in those strategies and plans.

3.3. Receive and consider projects of major strategic organisational change where there is a significant impact on our people's health and wellbeing, and cultural change.

Culture

3.4. Receive assurance that the Trust's behaviours are embedded, ensuring a continued journey of positive culture change.

3.5. Consider the experience of our people, including volunteers, and seek assurance of the effectiveness of mechanisms used for measuring, and for hearing and acting upon their experiences.

3.6. Receive assurance that there is a robust plan in place for the health and wellbeing of our people and monitor the effectiveness of arrangements in place to support and protect the mental, physical, and financial wellbeing of staff.

3.7. Receive assurance that Trust management and Trade Union Partners continue to develop and build a shared understanding and common purpose through formal and informal consultative partnership working to ensure the efficiency

and success of the Trust for the benefit of all. Review any partnership agreements with Trade Union Partners.

3.8. With respect to equality, diversity and inclusion the committee will:

(a) Oversee and contribute to the development of the Trust's equality, diversity and inclusion plan

(b) Receive assurance on its implementation and desired outcomes

(c) champion and support the plan and the work of the equality, diversity, and inclusion networks

(d) Receive assurance that there are effective arrangements are in place to meet the Welsh Language Standards and that the culture of Wales and the Welsh language is promoted within the Trust.

3.9. With respect to speaking up safely the committee will:

(a) Receive assurance that arrangements are in place to allow staff to raise concerns in confidence

(b) Ensure that those processes allow any such concerns to be investigated proportionately and independently

(c) Receive assurance that the learning from such concerns is considered and applied.

3.10. Receive assurance that the Trust has in place appropriate policies and procedures for its people and approve people and culture policies.

Capacity

3.11. Receive assurance on the development and implementation of the Trust's recruitment and retention plans, including those for volunteers.

3.12. Receive assurance that workforce and resourcing plans are fit for purpose and ensures the right resources and skills mix in the right place at the right time (both clinical and non-clinical)

Capability

~~3.13.~~ Ensure that the Trust has comprehensive leadership development and succession planning programmes in place to support leaders at all levels of the organisation and which is designed to reinforce the culture the Trust is

seeking to achieve.

3.13. Provide oversight of the Trust's approach to education, training, and development for all staff, ensuring programmes are comprehensive, accessible, and aligned with organisational priorities and values

3.14. Ensure the Trust maintains strong, collaborative relationships with its education partners, and ~~Receive~~ review and endorse the commissioning intentions for training and education through HEIW and other relevant bodies.~~s~~

3.15. Receive assurance that professional standards of registration and revalidation are maintained.

3.16. Advise the board on a set of key performance indicators (KPIs) for the responsibilities in its remit and monitor performance. These KPIs may include but not be limited to sickness absence, performance appraisal reviews, statutory and mandatory training, incidents of violence and aggression, disciplinaries and suspensions, turnover and recruitment; enabling deep dives to take place into specific areas of concern.

3.17. Ensure the Trust is discharging its statutory responsibilities, including but not limited to health and safety; equality, diversity, and inclusion; relevant Health and Care Quality Standards requirements; and that professional standards of registration and revalidation are maintained.

Risk and Audit

3.18. oversee the effective management of strategic and principal risks, as set out within the Board Assurance Framework (BAF), as appropriate to the purpose of the committee.

3.19. Receive and gain assurance from internal and external audits in their remit. The committee will receive assurance that management actions to address recommendations are in place via the audit tracker and receive appropriate reporting as agreed by the Audit, Risk and Assurance Committee. This committee will, where appropriate, scrutinise the impact of actions in response to audit recommendations.

4. AUTHORITY

4.1. The committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the committee.

4.2. The committee is authorised by the board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

4.3. The committee is authorised to approve Trust wide policies other than those policies reserved to the Board~~in accordance with the policy for the Review, Development and Approval of Policies~~.

Chair's Action

4.4. There may, occasionally, be circumstances where decisions which would normally be made by the committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

4.5. In these circumstances, the Chair and the Lead Executive, supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

4.6. The Director of Corporate Governance/Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Sub-Committees

4.7. The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the board.

4.8. The Welsh Ambulance Services Partnership Team (WASPT) is an advisory group of the Board and was re-constituted in November 2022 following the pandemic. The Board has agreed that WASPT is a sub-committee of this Committee and as such reports regularly by way of a AAA highlight report. Similarly, issues raised are reported, and where necessary escalated, to the Board by way of this Committee's AAA highlight report.

5. MEMBERSHIP AND QUORUM

5.1. The Trust's Standing Orders at 3.3.5 and 3.3.6 provide the rules around committee membership. That includes that the designation of Chair, definition of member roles and powers and terms and conditions of appointment are determined by the board, based on the recommendation of the Trust Chair. Executive Directors and other Trust officers cannot be appointed as committee Chairs, nor should they be appointed to serve as 'members' on any Committee set up to review the exercise of functions delegated to them. They may however be 'in attendance' as appropriate.

5.2. The application of these provisions means that the designation of 'members' in NHS Wales committees is applied to Non-Executive Directors. This ensures there is independent scrutiny, support and challenge, and is a relevant for quorum (see below) and – where it is required – for voting

5.3. Notwithstanding the above, the 'members' and 'prescribed attendees' listed below are often referred to collectively as members or membership

Committee Membership

5.4. The committee will comprise four Non-Executive Directors, one of whom will be designated as Chair, and the following prescribed attendees:

- Director of People (Joint Executive Lead)
- Director of Cultural Change (Joint Executive Lead)
- Executive Director of Finance and Corporate Resources
- Executive Director of Operations
- Director of Partnerships and Engagement
- Executive Director of Paramedicine
- Deputy Director of Nursing, Quality and Governance

- Assistant Director of Planning and Transformation
- Freedom to Speak Up Guardian
- Trade Union Partners (x4)
- Chairs of Sub-Committees (or their nominee)
- Director of Corporate Governance/Board Secretary
- Head of Workforce Education and Development

5.5. In the absence of the committee Chair, one of those in attendance must be designated as Chair of the meeting.

5.6. Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Director of Corporate Governance/Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

5.7. The Chair of the Trust Board and the Chief Executive have a standing invitation to attend meetings. In addition, the Committee Chair may invite others (either Trust staff or persons outside the Trust) to attend all or part of the meeting to assist with its discussions on any particular matter. The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge, and expertise

Quorum

5.8. The quorum for meetings of the committee shall be two Non-Executive Directors.

5.9. While only two Non-Executive Directors are required for quorum, it is strongly recommended that all three Non-Executive Director members be present at each meeting to ensure robust discussion and effective oversight. The presence of all Non-Executive Directors is crucial for fostering diverse perspectives and maintaining rigorous challenge and scrutiny. Therefore, other Non-Executive Directors of the board may be co-opted to meetings where it is not possible for all three Non-Executive Directors to attend

Member Appointments

5.10. The membership of the Committee shall be determined by the board, based

on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

5.11. Non-Executive Directors shall be appointed to hold office for a period of one year at a time, (membership being reviewed by the Chairman of the board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the board.

5.12. Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

6. COMMITTEE MEETINGS

Secretariat and Support to Committee Members

6.1. The Director of Corporate Governance/Board Secretary, on behalf of the Committee Chair, shall:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme.

Frequency of Meetings

6.2. Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of board Business. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

Withdrawal of individuals in attendance

6.3. The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

7. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1. The Committee is directly accountable to the board for its performance in exercising the functions set out in these terms of reference.

7.2. The Committee, through its Chair and members, shall work closely with the board's other committees and groups to provide advice and assurance to the board through the:

(a) joint planning and co-ordination of board and Committee business; and

(b) sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the board's overall assurance framework.

7.3. The Committee will consider the assurance provided through the work of the board's other committees and sub-groups to meet its responsibilities for advising the board on the adequacy of the Trust's overall framework of assurance.

7.4. The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1. The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes a written highlight report, the submission of Committee minutes and written reports where appropriate throughout the year;

(b) bring to the board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

8.2. The Director of Corporate Governance/Board Secretary, on behalf of the board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1. The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 6)

10. REVIEW

10.1. These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2025/26~~2026/27

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The board may and, where directed by the Welsh Government must, appoint committees of the Trust either to undertake specific functions on the board's behalf or to provide advice and assurance to the board in the exercise of its functions. The board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2. In line with Standing Orders the board shall nominate annually a committee to be known as the **Finance and Performance Committee** (the 'committee'). The detailed terms of reference and operating arrangements set by the board in respect of this committee are set out below.

1.3. committees play an important role in supporting the board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the board's behalf; and
- providing a forum where ideas can be explored in greater detail than board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the board on the issues within the committee's remit allow for more focused discussions by the board.

2. PURPOSE

The purpose of the Finance and Performance committee is to enable scrutiny and review of the Trust's arrangements in respect of the:

2.1 overall financial position (both capital and revenue) of the Trust and its compliance with statutory financial duties;

2.2 ability of the Trust to deliver on its core objectives as set out in the Integrated Medium Term Plan (IMTP);

2.3 monitoring of the IMTP and ensuring achievement of key milestones;

2.4 robustness of any cost improvement measures and delivery of key strategies and plans;

2.5 ensure development of the long term strategy and delivery of the Trust's strategic aims in relation to value and efficiency, including an increased focus on benchmarking;

2.6 scrutinise business cases for capital and other investment;

2.7 oversight of the development and implementation of the digital, estates, fleet, and environmental strategies; information governance and information security; and business continuity including emergency preparedness, resilience and response, cyber security, and cyber resilience.

2.8 The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.9 The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the

committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

2.10 In alignment with the Wellbeing of Future Generations (Wales) Act 2015, this committee will adopting a long-term perspective in its deliberations and decisions. The committee will consider the broader implications of its actions, particularly in relation to the three wellbeing objectives established by the trust in order to contribute positively to the wellbeing of future generations. These objectives are: 1) being a socially responsible and inclusive employer, 2) fostering an innovative and sustainable organization, and 3) ensuring we are a proactive, accessible, and equitable care provider

3. DELEGATED RESPONSIBILITY

With regard to its role in providing advice and assurance to the board, the committee will specifically:

Strategic Development and Delivery

Long Term Strategy

3.1 Oversee and contribute to the development of the Trust's long term strategic direction and make recommendations to the board for its approval, including any adjustments to the Trust's current long term strategy, Delivering Excellence: Our Vision for 2030.

3.2 Oversee and contribute to the development of the Trust's Integrated Medium Term Plan (IMTP) and ensure alignment of that plan to deliver the long-term strategy.

3.3 Monitor and review progress against the IMTP.

Long Term Plans

3.4 Oversee and contribute to the development of the long term plans associated with Delivering Excellence: Our Vision for 2030, including but not limited to:

- Estates plan
- Fleet plan

- Digital plan
- Environmental plan
- Commercial development plan
- Wellbeing objectives

3.5 Hold a central overview of all long term plans that align to the long term strategy. These plans will be reviewed for alignment by the relevant committee first and their implementation will be guided by the IMTP or relevant local directorate plans.

Finance

3.6 Oversee and contribute to the financial strategy, in relation to both revenue and capital.

3.7 Monitor the Trust's in-year and forecast revenue financial position against budget and review and make appropriate recommendations for corrective action where required.

3.8 Monitor progress against the Trust's capital programmes including for estates, fleet and digital

3.9 Receive, review and ensure mitigation of financial risks of delivery of plans;

3.10 Review progress against the Trust's annual operating framework and make recommendations to the board in relation to development of the annual financial plan and budget setting and financial strategy, financial sustainability programmes, efficiency review implementation and required savings targets.

3.11 Review performance against the relevant Welsh Government financial requirements.

3.12 In accordance with the Scheme of Reservation and Delegation:
- Review all business cases and contract awards for approval by the board and
- Consider whether post implementation evaluations of the above will return for key learning points.

Commercial

3.13 Receive assurance on the development of commercial partnerships and the Trust's commercial framework when developed.

~~**Value Based Healthcare**~~

~~3.14 Receive assurance on delivery of core aims in relation to delivering value and development of value based health care in an out of hospital setting.~~

Performance

~~3.15~~3.14 Review performance against targets and standards set by Commissioners and/or Welsh Government for the Trust and, where appropriate, against national ambulance quality indicators.

~~3.16~~3.15 Review the effectiveness of the Trust's Quality and Performance Management Framework and receive assurance on the value of outcomes produced by the framework.

~~3.17~~3.16 Endorse (and recommend to the board) and monitor progress and ensure the development of robust intelligent targets against:

- Board level key performance indicators (KPIs) in the Monthly Integrated Quality and Performance Report (MIQPR).
- KPIs reporting outside of the MIQPR including digital systems and information governance and information security

~~3.18~~3.17 Monitor and review plans to recover areas of underperformance, reviewing where appropriate associated KPIs as part of any deep dives, and providing assurance to the board and escalating to the board or a relevant committee as required.

Planning

~~3.19~~3.18 Monitor the effectiveness of commissioning arrangements.

~~3.20~~3.19 Review and consider matters relating to demand and capacity including proposals for reviews in this area and recommendations arising from such reviews.

Infrastructure

~~3.21~~3.20 Review proposals for acquisition, disposal, and change of use of land/buildings.

~~3.22~~3.21 Receive assurance on compliance with environmental regulations and national targets in relation to the environment and sustainability.

~~3.23~~3.22 Receive assurance on compliance with fire safety and waste regulations.

Business Continuity and Cyber

~~3.24~~3.23 Oversight and scrutiny of the Major Incident Plan and Business Continuity Plan and receive assurance that such plans are effective.

~~3.25~~3.24 Oversight and scrutiny of cyber resilience including assurance on awareness and training of WAST staff and volunteers; maintenance of upgrades/updates of systems, and replacement of legacy/high-risk systems.

~~3.26~~3.25 Oversight and scrutiny of cyber security including assurance of regular monitoring of risks and threats, business continuity planning and engagement with national cyber centres and stakeholders.

Information Governance and Information Security

~~3.27~~3.26 Receive assurance the information governance and information security arrangements are appropriately designed and operating effectively to ensure the reliability, integrity, safety, and security of information to support the delivery of high quality, safe healthcare across the organisation.

~~3.28~~3.27 Review progress of measures to improve information security and adherence to Caldicott principles against the Information Governance Toolkit, Network and Information Systems (NIS) Directive (2018), Data Protection Act (2018), and receive assurance on compliance with relevant standards, legislation and regulations.

~~3.29~~3.28 Receive assurance on, and review effectiveness of the Trust's information security protocols.

~~3.30~~3.29 Review performance of the Trust in relation to statutory and mandatory information requests and reporting requirements including but not limited to freedom of information requests, data breaches, police requests and subject access requests.

Policies

~~3.31~~3.30 Approval of policies within the remit of the committee

Risk and Audit

~~3.32~~3.31 Oversee the effective management of strategic and principal risks, as set out within the Board Assurance Framework (BAF), as appropriate to the purpose of the committee.

~~3.33~~3.32 Receive and gain assurance from internal and external audits in their remit. The committee will receive assurance that management actions to address recommendations are in place via the audit tracker and receive appropriate reporting as agreed by the Audit, Risk and Assurance committee. This committee will, where appropriate, scrutinise the impact of actions in response to audit recommendations.

4. AUTHORITY

4.1 The committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the committee.

4.2 The committee is authorised by the board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

4.3 The committee is authorised to approve Trust wide policies other than those policies reserved to the Board~~in accordance with the policy for the Review, Development and Approval of Policies~~.

Chair's Action

4.4 There may, occasionally, be circumstances where decisions which would normally be made by the committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

4.5 In these circumstances, the Chair, and the Lead Executive, supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the committee after first consulting with at least two other Members (Non-Executive Directors).

4.6 The Director of Corporate Governance/Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the committee for consideration and ratification.

4.7 **Sub-committees**
The committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of committee business. Formal sub-committees may only be established with the agreement of the board.

5. MEMBERSHIP AND QUORUM

5.1 The Trust's Standing Orders at 3.3.5 and 3.3.6 provide the rules around committee membership. That includes that the designation of Chair, definition of member roles and powers and terms and conditions of appointment are determined by the board, based on the recommendation of the Trust Chair. Executive Directors and other Trust officers cannot be appointed as committee Chairs, nor should they be appointed to serve as 'members' on any Committee set up to review the exercise of functions delegated to them. They may however be 'in attendance' as appropriate.

5.2 The application of these provisions means that the designation of 'members' in NHS Wales committees is applied to Non-Executive Directors. This ensures there is independent scrutiny, support and challenge, and is a relevant for quorum (see below) and – where it is required – for voting

5.3 Notwithstanding the above, the 'members' and 'prescribed attendees' listed below are often referred to collectively as members or membership.

Committee Membership

5.4 The will comprise three Non-Executive Directors, one of whom will be designated as Chair, and the following prescribed attendees :

- Executive Director of Finance and Corporate Resources (Joint committee Lead)
- Executive Director of Strategy, Planning and Performance (Joint committee Lead)
- Executive Director of Operations
- Executive Director of Quality and Nursing
- Director of People
- Director of Digital
- Trade Union Partners (x 2)
- Director of Corporate Governance/Board Secretary
- Head of Commercial (when appointed)
- Chairs of Sub-committees (if any)

5.5 In the absence of the committee Chair, one of those in attendance must be designated as Chair of the meeting.

5.6 Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Director of Corporate Governance/Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

5.7 The Chair of the Trust Board and the Chief Executive have a standing invitation to attend meetings. In addition, the Committee Chair may invite others (either Trust staff or persons outside the Trust) attend all or part of the meeting to assist with its discussions on any particular matter. The Committee

may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge, and expertise

Quorum

5.8 The quorum for meetings of the committee shall be two Non-Executive Directors.

5.9 While only two Non-Executive Directors are required for quorum, it is strongly recommended that all three Non-Executive Director members be present at each meeting to ensure robust discussion and effective oversight. The presence of all Non-Executive Directors is crucial for fostering diverse perspectives and maintaining rigorous challenge and scrutiny. Therefore, other Non-Executive Directors of the board may be co-opted to meetings where it is not possible for all three Non-Executive Directors to attend.

Member Appointments

5.10 The membership of the committee shall be determined by the board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

5.11 Non-Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the board.

5.12 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration committee.

6. COMMITTEE MEETINGS

Secretariat and Support to committee Members

6.1 The Director of Corporate Governance/Board Secretary, on behalf of the committee Chair, shall:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture.

Frequency of Meetings

6.2 Meetings shall be held bi-monthly or otherwise as the Chair of the committee deems necessary, consistent with the Trust's annual plan of board business. Meeting agendas, papers and minutes shall be circulated no less than seven days prior to each meeting.

Withdrawal of individuals in attendance

6.3 The committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1 The committee is directly accountable to the board for its performance in exercising the functions set out in these terms of reference.

7.2 The committee, through its Chair and members, shall work closely with the board's other committees and groups to provide advice and assurance to the board through the:

- joint planning and co-ordination of board and committee business; and
- sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the board's overall assurance framework.

7.3 The committee will consider the assurance provided through the work of the board's other committees and sub-groups to meet its responsibilities for advising the board on the adequacy of the Trust's overall framework of assurance.

7.4 The committee shall embed the Trust's corporate standards, priorities, and requirements, e.g. equality and human rights through the conduct of its business.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The committee Chair shall:

(a) report formally, regularly and on a timely basis to the board and the Chief Executive (Accountable Officer) on the committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports where appropriate throughout the year;

(b) bring to the board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

8.2 The Director of Corporate Governance/Board Secretary, on behalf of the board, shall oversee a process of regular and rigorous self-assessment and

evaluation of the committee's performance and operation including that of any sub committees established.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the committee, except in the following areas:

- Quorum (as set out in section 5)

10. REVIEW

10.1 These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

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

Agenda Item No.	08

REPORT TITLE

Risk Management & Board Assurance Framework

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	02 December 2025
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 includes details of the work undertaken to develop a suite of Risk Appetite Statements, a progress update on the management of the Trust's principal risks, and an update on the risk management work programme for 2025/26.

Risk Appetite Statements

2. The Board is expected to approve the Risk Appetite Statements (RAs), at its meeting on 27 November 2025, which set out the amount and type of risk the Board is willing to take in pursuit of its strategic objectives which are described in the Trust's Long Term Strategy: Delivering Excellence 2030.

3. The suite of seven RAs has been developed throughout 2025, and approval formalises the work undertaken at Board Development sessions and through internal committee review.

4. The Board will set the Trust's Risk Appetite annually, or sooner if required by material change and the Audit, Risk and Assurance Committee (ARAC) will oversee the next steps in relation to communication, implementation and assurance, as part of the 2026/27 work programme.

Principal Risk Activity

5. Members can take assurance that each of the Trust's principal risks have been reviewed in line with the agreed schedule detailed at Annex 3 and that the Executive Leadership Team (ELT) approved the principal risk activity on 29 October 2025 undertaken by Risk Owners.

6. The report outlines the broader discussions across the senior leadership teams and the committees on the higher rated risks. The Risk Owners have an opportunity to further add to the narrative within the report and detail of any assurances or escalations during the meeting.

7. Members are asked to note the work undertaken on the Trust's reputation Risk 201 which has been disaggregated into two separate risks following a reframing exercise. These are Risks 201a *Relationships with Stakeholders* and 201b *Poor Patient Experience Affecting Reputation* both scoring 16 (4x4) with targets of 12 (3x4).

8. The full detail of both these reputational risks will be included in future Risk Reports and members are asked to note that oversight will sit with the Trust Board rather than the People & Culture Committee moving forward as the scope of these risks extends beyond staff engagement. In the meantime, the Board Assurance Framework (BAF) entry for Risk 201 has been removed from this report.

9. 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* will be considered as part of this work as to whether it could be amalgamated into the new Stakeholder Reputation risk.

10. Whilst there have been no other material changes to the principal risks during this period the report foreshadows the development of a new risk which articulates the financial position for the next financial year and the consequence of this in relation to patient safety and digital programmes and may see the amalgamation of a several current corporate risks.

High Level Summary of the 2025/26 Work Programme and Progress

11. The outline programme of work includes:
    a. June 2025: Repositioning Risks 223 and 224 *(Complete)*
    b. July 2025: Anticipated appointment of a Risk Manager to the team *(Complete)*
    c. July 2025: Electronic Risk Management system demos *(Complete)*
    d. August / September 2025: Finalise Risk Appetite Statements (RAs) *(Complete)*
    e. November 2025: Sign off RAs by the Trust Board *(Scheduled)*
    f. November/December 2025: Testing the market for a new Risk Management System *(Ongoing)*

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to:

1. Consider and discuss the contents of the report.
2. Consider the suite of seven Risk Appetite Statements and the next steps for implementation and monitoring of these, as part of the 2026/27 work programme.
3. Receive an update on the 2025/26 programme of work.
4. Receive assurance on the review and attention to the principal risks and their review at the Executive Leadership Team and at relevant Committees.
5. Note that the reframed Reputational Risks 201a and 201b are overseen by the Board rather than the People & Culture Committee in future.
6. Note the ratings, mitigating actions and scoring trends for each principal risk.

ADDITIONAL PAPER(S)

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

1. The Trust Board is requested to receive the following:
   a. Annex 1 - Summary table describing the Trust's Principal Risks.
   b. Annex 2 – Scoring Matrix
   c. Annex 3 – Frequency of Risk Review
   d. Annex 4 – Board Assurance Framework (Ibabs Reading Room)
   e. 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
29 October 2025	Executive Leadership Team
04 November 2025	Quality, Patient Experience & Safety Committee
13 November 2025	People & Culture Committee
18 November 2025	Finance & Performance Committee
27 November 2025	Trust Board

SITUATION

1. The purpose of the report is threefold; firstly, to provide details of the work undertaken to develop a suite of Risk Appetite Statements which are being presented to the Board on 27 November 2025 for approval; secondly a progress update on the management of the Trust's principal risks, and finally, an update on the risk management work programme for 2025/26.

BACKGROUND

2. The Risk Management programme, overseen by the Audit, Risk & Assurance Committee (ARAC) and monitored through the Corporate Governance Directorate Plan, has included the development of a suite of Risk Appetite Statements (RAs) during 2025/26. The outcome of this work is presented in this paper, recognising that the Trust Board should annually agree and set the risk appetite against each of its strategic objectives.

3. The Trust's principal risks, as outlined in this paper, are allocated to Directors who lead reviews and mitigating actions. In addition to directorate reviews, formal risk review discussions are held by the Executive Leadership Team (ELT) concerning risk escalation, changes in ratings, and new risks for inclusion on the Corporate Risk Register (CRR).

4. This report demonstrates the sustained focus on risk management, not only through risk discussions in various forums but also through broader attention to planned mitigations across the system.

ASSESSMENT

Risk Appetite Statements

5. The Board began developing the suite of RAs in February 2025, which concluded at the Board Development Day held on 19 September 2025 following prior consideration by internal committees.

6. The RAs define the level and type of risk that the Trust is willing to take or accept in pursuit of its strategic objectives, supporting better outcomes for our patients, our people and communities and in working with our partners and stakeholders.

7. Seven RAs have been developed and aligned to the Trust six strategic objectives as outlined in the Long Term Strategy: Delivering Excellence 2030. Their development involved articulating risk appetite definitions, agreeing narrative, as well as the level of appetite against each strategic objective.

8. Overall, the Trust is open to embracing greater risk and opportunities to enhance our service delivery, improve our people's capabilities, advance innovation and technology, collaborate with partners, adopt new clinical practices and quality initiatives and enhance our service offerings and overall value.

9. Once implemented, the RAs are intended to guide decision making by the Board and ELT in the future supported by the narrative within each statement.

Risk Appetite Statement Definitions

10. The risk appetite is articulated across five levels, each guiding the Trust's approach to risk in pursuit of its strategic objectives. The definitions of these five levels are as follows:

1) **Averse:** Low tolerance to risk and preference for conservative risk taking. The priority is organisational preservation with lower but stable returns.
2) **Minimal:** Willing to accept a limited level of risk in pursuit of modest returns. Prioritisation and focus on low-risk investments.
3) **Cautious:** Cautious view to taking risks. Seeking balance between risk and reward, aiming for reasonable returns while considering risk. Careful evaluation of potential risk related to strategic decisions.
4) **Open:** Keen to embrace higher risks in pursuit of achieving higher returns. Actively seeking opportunities and open to exploring innovative solutions. Robust risk management practices in place to mitigate potential risks.
5) **Keen:** High risk appetite, actively seeking high-reward opportunities. Prioritising decisions for maximum returns and willing to accept significant levels of risk to achieve financial and operational goals.

11. The table below describes the level of risk appetite for each of the six objectives. Strategic Objective six has been separated into two parts to reflect differences in appetite – the first covers financial probity, performance, and sustainability, value-based healthcare, and value for money; the second covers commercial innovation, foundation economy, and environmental sustainability.

Risk Appetite Statements by Strategic Objective

Strategic Objective	Appetite Level	Context
SO1: Providing the right care or advice, in the right place, every time	Open	Willingness to innovate and change current processes to improve our ability to provide the right care or advice, in the right place, every time. Open to taking risks regarding changes to processes impacting the right care or advice. We understand that innovation and improvement may involve some risk, and we are prepared to embrace opportunities to enhance service delivery.
SO2: Enabling our people to be the best they can be	Open	Fostering a positive culture to promote, develop, and motivate our people through providing support for upskilling, comprehensive training, and personal development. We are willing to embrace more risk to achieve significant improvements in people's capabilities and culture to thrive. We understand that fostering innovation and personal growth may involve some

		risk, and we are prepared to embrace these opportunities to enhance our team's capabilities and performance.
SO3: Being at the forefront of innovation and technology	Keen	Driving change through innovation and developing technological capabilities and championing this in the sector. We are keen to lead in innovation and technology, actively seeking and embracing new opportunities. We will take calculated risks to be at the cutting edge, always prioritising the potential benefits for our service and the communities we serve.
SO4: Developing services in collaboration	Open	Willingness to collaborate with other partners to achieve strategic objectives and comply with statutory requirements. We are open to risk when developing services in collaboration with other partners to enhance service delivery and community impact. We are prepared to embrace these opportunities while managing any associated risks.
SO5: Being quality driven and clinically led	Open	Prioritises adherence to clinical standards and continuous improvement in quality. Acknowledges that some risk is inherent in healthcare but commits to minimising harm through governance and learning. We are open to taking measured risks to advance our commitment to being quality driven and clinically led recognising that some degree of patient harm is inherent within complex healthcare systems. We are open to taking measured risks that support continuous improvement, innovation and the adoption of new clinical practices. While we accept that not all harm can be eliminated, we will actively minimise and mitigate it through robust governance, evidence-based decision-making and a culture of learning and accountability.
SO6a: Financial Sustainability	Cautious	Encompasses financial probity, performance, and sustainability, value-based healthcare, and value for money. Seeks to maximise value for service users and stakeholders We balance risk and reward to implement measured financial improvements. This includes prudent budgeting, targeted savings, and robust oversight of financial performance and planning. Improvements are implemented in a controlled and measured manner.

SO6b: Commercial/Foundation Economy, Value-Based Healthcare & Environmental Sustainability	Open	Encompasses commercial innovation, foundation economy, and environmental sustainability. Seeks to maximise value for service users and stakeholders. We are willing to embrace higher risks to achieve significant improvements in delivering exceptional value. We actively seek opportunities and are open to exploring innovative solutions, with robust risk management practices in place to mitigate potential risks. We are prepared to take calculated risks to enhance our service offerings and overall value and to seek a higher reward and ROI.

Risk Appetite Statements – Next Steps

12. The ARAC will oversee the next steps for the Risk Appetite Statements which will be included in the 2026/27 programme of work. This will include:

- Development of a guideline on the use of Risk Appetite as an agreed action in the 2024/25 Internal Audit review to outline how the risk appetite can effectively be employed as a key strategic tool and to enhance decision making by the Board.
- Consideration of the risk appetite thresholds and tolerances and to test how the Trust may these for decision making.
- Designing risk appetite monitoring metrics and set up a reporting mechanism to monitor compliance against the risk appetite limits.

Risk Management Work Programme

13. Work to determine metrics for scoring internal and external factors on Risks 223 and 224 is underway and this will include testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death.

14. The Trust's team continue to explore options for a new digital risk management solution, and a scope has been developed as an exercise to test the market. Responses will help us understand available solutions, their alignment with the Trust's requirements, indicative costs, and implementation timelines.

15. This represents the next step in our risk maturity journey by providing a modern, integrated, digital platform to manage risk effectively at all levels throughout the Trust. By way of assurance for committee; the Trust will remain on the current Datix Risk Web module at no additional cost until November 2027.

16. The team intend to develop and pilot one or two strategic risks against the strategic objectives as part of next year's work programme.

Risk Management Policy

17. Members are asked to note that the Risk Management Policy and guidance will be updated to reflect the Board's position on risk appetite and its operationalisation through the BAF/CRR and committee structures. This will be considered by the ARAC and brought back to the March 2026 meeting for approval.

Principal Risks

18. The ELT approved the principal risk activity on 29 October 2025 having considered the review of each risk undertaken throughout the period by Risk Owners.

19. A summary table of these risks is set out in Annex 1 with a detailed description of each contained within the Board Assurance Framework (BAF) at Annex 4. All updates are highlighted in blue on the BAF.

20. 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.

21. 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.

22. The Trust's highest rated **Risks 223** *the Trust's inability to reach patients in the community causing patient harm and death* and **Risk 224** *significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service*, remain static at the highest score of 25.

23. While the Trust continues to demonstrate high levels of internal assurance, recent national focus on care standards and system performance provides a welcome 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 to which the Trust can mitigate this risk through internal controls alone. However, increasing national scrutiny, greater transparency, and a shift toward more integrated, system-based accountability present a clear opportunity to improve consistency and collective impact across organisational boundaries.

24. The introduction of W45 from 1 October 2025 and the efforts made by the majority of Health Boards in the preceding months, is a welcome step toward reducing avoidable patient harm by supporting more timely transfers of care and improving the overall experience for patients awaiting treatment. A clinically led Handover-45 taskforce has

been formed and workshops hosted by the NHS Wales Performance and Improvement are ongoing to support local improvement plans.

25. The Audit Wales report, published in June 2025, regarding the effectiveness of unscheduled care arrangements across NHS Wales provides a critical external perspective on whole-system performance and identifies further levers to drive national consistency and accountability. Achieving the target risk score will ultimately rely on sustained partnership working, improved operational alignment across organisations, and the embedding of nationally agreed standards into routine delivery at every level of the system.

26. Phase one of the Trust's Clinical Transformation Model - specifically the introduction of Code Changes for response was successfully implemented on 1 July 2025, representing a key milestone in the delivery of an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. Work towards the go live of Phase two is underway.

27. Strategic mitigation remains focused on both internal transformation and system-wide influence. The Trust continues to engage proactively with national and regional programmes - including the Six Goals for Urgent and Emergency Care - to support shared learning, alignment of expectations, and strengthened collective ownership of outcomes.

28. The risk data is being presented in themes and categories and supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level.

29. The risks continue to be reported to the Trust Board, with a focus on the actions to mitigate these two risks that are within its control, and these are highlighted in the avoidable harm dashboard that is presented at each Board meeting. Further mitigations and transformative actions are described in the Integrated Medium Term Plan (IMTP) and are presented to committees and Trust Board in a variety of reports e.g. IMTP Assurance Report and described in the Monthly Integrated Quality & Performance Report to address these risks.

30. Most of the Trust's actions in the avoidable harm dashboard have been completed and several efficiencies and improvements implemented that have stabilised performance; however, the Trust is unable to completely mitigate the scale of handover lost hours due to the environment which it is operating in.

31. The Quality, Patient Experience and Safety Committee (QuEST) reviewed both risks at its meeting in November 2025 with the Agenda items reflecting the controls and mitigations discussed at this meeting. These risks continue to be escalated to the Board via the meeting's Alert, Assure and Advise (AAA) report.

32. Members are asked to note that **Risk 201** *A loss of stakeholder confidence that damages the Trust's reputation*, has been reframed during this reporting period and disaggregated

into two separate risks which are described in sections 8.1 and 8.2 below. The BAF extract for Risk 201 has not been included in the report before Committee today.

32.1. **Risk 201a** *Relationships with Stakeholders*

IF *the organisation fails to engage key stakeholders (e.g. WG, Audit Wales, Internal Audit, HIW, HBs, LAs, JCC) 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*

32.2. **201b** *Poor Patient Experience Affecting Reputation*

IF *a patient receives a poor experience from the Trust and it receives negative regulatory reports or media scrutiny*

THEN *public trust 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, high-quality care*

33. This approach aims to address the different aspects of reputation and ensure that the Trust's risks are accurately profiled.

34. The ELT approved the inclusion of **Risks 201a** and **201b** on the Corporate Risk Register both at score of 16 (4x4) with a target score of 12 (3x4). The full detail of these risks including controls, assurances, gaps and mitigating actions will be included in future reports.

35. Members are asked to note that oversight will now sit with the Trust Board rather than the People & Culture Committee as the scope of these risks extends beyond staff engagement.

36. **Risk 260** *A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems* remains static at a score of 20 (4x5) due to the escalated world conflicts and recent increase in targeted cyber-attacks. The risk is reviewed in closed sessions of committees and Trust Board 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 open session; however, the full detail is not included in Annex 4. The risk will be

discussed in closed session of Trust Board today and by the closed meeting of the Finance & Performance Committee (FPC) on 18 November 2025.

37. **Risk 641** *The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident* remains static at a score of 20 (4x5). This risk is taken in open session of the Board in full transparency. However, members will note that the actions to address individual recommendations are not included in detail in the BAF extract. This is for reasons of sensitivity and security.

38. **Risk 160** *High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service*, remains static at a score of 16 (4x4) during this review period, reflecting that the rolling annual figures for sickness since March 2022 are reducing year on year and therefore a reduction in the score is appropriate. This will be closely monitored by the People & Culture team and Executive Leadership Team.

39. **Risk 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* remains static at a score of 16 (4x4). Work is underway to reposition the risk utilising the new approach to separate controls, assurances and gaps into internal and external themes and categories; those that the Trust manages and those that it monitors. Each of the assurances against the controls will be described over three lines of assurance in readiness for the Finance & Performance Committee meeting in January 2026.

40. **Risk 671** *Unauthorised or Inappropriate use of AI technologies* was developed and approved for inclusion on the Corporate Risk Register, by the ELT in September 2025, at a score of 16 (4x4) with a target of 8 (2x4). The high level detail of the risk was included in the previous report; however, the full detail of the risk is now included in the BAF at Annex 4.

41. **Risk 558** *Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures,* currently remains unchanged at a score of 15 (3x5); however, work is underway to consider the current actions and mitigations against this risk and to articulate the work that will support this risk to target.

42. **Risk 594** *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* and **Risk 623** *Failure to comply with Data Protection Legislation* remain unchanged this period and static at a score of 15 (3x5).

43. **Risk 100** *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* remains static at a score of 12 (3x4) during this period; however, this risk will be considered more closely to determine whether it can be factored into the new relationships with stakeholders reputation risk which is before the Trust Board at its next meeting on 27 November 2025.

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

45. **Risk 139** *Failure to Deliver our Statutory Financial Duties* remains unchanged at a score of 8 (2x4) during this period; however, this risk will be considered in close detail in the next round in line with the financial position for 2026/27.

Risk Trending Data

46. A dashboard describing principal risk score trends from March 2023 and their movement over time has been produced and is attached at Annex 5. A heat map of these risks will be developed once work commences to map these risks to the overarching strategic risks in development; those that will prevent the Trust from achieving its strategic objectives.

47. 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.

48. The use of risk appetite going forward will support a more prescribed interrogation of the risk data as it informs risk scoring, target setting, escalation and assurance mapping of each of the risks.

49. Earlier in the year, Directors each received a dashboard showing the number of mitigating actions against each of the principal risks, their completion dates and the anticipated impact on the target scores. Building on this work, Directors and their teams are asked to discuss risk mitigation with a closer focus on the actions required to achieve target scores and to test whether the risks are well controlled despite scores remaining static as well as the level of risk being carried.

RECOMMENDATION

50. The recommendations are as set out in the front cover above.

NEXT STEPS

51. The implementation and monitoring of the Risk Appetite Statements will be presented to the Audit, Risk and Assurance Committee (ARAC) for oversight, as part of the 2026/27 work programme.

52. A detailed review of each principal risk is underway with the outcome reported to the ELT on 31 December 2025 for discussion and approval of the activity.

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death.	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Executive Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service.	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Executive Director of Quality & Nursing	**25 (5x5)** →
201 PCC	A loss of stakeholder confidence that damages the Trust's reputation.	**IF** there is an inability of the Trust to deliver its core services because of system or organisational pressures **THEN** there will be a loss of stakeholder confidence in the Trust **RESULTING IN** a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny	Director of Partnerships & Engagement	**20 (4x5)** →
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems.	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	Director of Digital Services	**20 (4x5)** →

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

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		compliance with other legislation, regulation and standards.		
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service.	**IF** there are high levels of absence **THEN** there is a risk that there is a reduced resource capacity **RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of People & Culture	**16 (4x4)** →
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	**IF** there is a lack of resources and available technology and infrastructure **THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines **RESULTING IN** negative environmental and social impacts causing and reputational damage	Executive Director of Finance & Corporate Resources	**16 (4x4)** →
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	**IF** significant internal and external system pressures continue **THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST **RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of People & Culture	**15 (3x5)** →
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients	Executive Director of Operations	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.		
623 FPC	Failure to comply with Data Protection Legislation	**IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality **THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used **RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.	Director of Digital Services	**15 (3x5)** →
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.	**IF** WAST fails to persuade JCC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered	Executive Director of Strategy Planning & Performance	**12 (3x4)** →
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	**IF** the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained	Director of People & Culture	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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.		
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation.	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Executive Director of Finance & Corporate Resources	**8 (2x4)** →

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

RISK TRENDING DATA																		
			Period															
Directorate	Risk ID	Risk Title	Mar-23	Jul-23	Sep-23	Nov-23	Mar-24	Jun-24	Sep-24	Nov-24	Mar-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
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	15	15	15	15	15	15	15	15	20	20	20	20	20	20
	623	Failure to comply with Data Protection Legislation						15	15	15	15	15	15	15	15	15
	543	Major disruptive incident resulting in a loss of critical IT systems	15	15	15	15	15	10								
	671	Unauthorised or inappropriate use of AI technologies												16	16	16
	620	Symptom Checkers									20	15	15	15	15	15
Finance and Corporate Resources	139	Failure to Deliver our Statutory Financial Duties in accordance with legislation	16	16	16	16	8	8	8	8	8	8	8	8	8	8
	542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan						16	16	16	16	16	16	16	16	16
	458	A confirmed commitment from JCC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	16	16	16	16	16									
Operations	223	Trust's inability to reach patients in the community causing patient harm and death	25	25	25	25	25	25	25	25	25	25	25	25	25	25
	594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	15	15	15	15	15	20	20	15	15	15	15	15	15	15
	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									20	20	20	20	20	20
	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	16	8												
	244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	12													
Partnership and Engagement	201	Damage to Trust reputation following a loss of stakeholder confidence	20	20	20	20	20	20	20	20	20	20	20	20	20	
	201a	Relationships with Stakeholders														16
	201b	Poor Patient Experience Affecting Reputation														16
People & Culture	160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	20	20	20	20	20	20	20	20	20	20	20	16	16	16
	163	Maintaining Effective & Strong Trade Union Partnerships	12	16	16	16	20	16	16	12	12	12	12	12	12	12
	558	Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures	15	15	15	15	15	15	15	15	15	15	15	15	15	15
	557	Potential impact on services as a result of Industrial Action	16	16												
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	25	25	25	25	25	25	25	25	25	25	25	25	25	25
	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	15	15	15	10										
	637	Diesel Fumes														
	538	Digital System Implementation			16											
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	12	12	12	12	12	12	12	12	12	12	12	12	12	12
	424	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	12	16	16	16	16	12	8							
	283	Failure to implement the EMS Operational Transformation Programme	12	12	12	12	12									

	Risk achieved target score and de-escalated to directorate level for ongoing monitoring
	Risk closed from all registers
	Risk not in existence

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

Agenda Item No.	09

REPORT TITLE

Audit Tracker 2025-26 Q2 Reporting (Jul-Sep25) – ARAC 021225 (Public)

MEETING

Name of meeting	Audit Risk and Assurance Committee
Date of meeting	02 December 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Lisa Trounce, Head of Compliance and Assurance

PURPOSE OF REPORT

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

EXECUTIVE SUMMARY:

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

1. This report outlines to the Audit, Risk and Assurance Committee (ARAC) the current position with respect to management actions for internal and external audits/reviews within the purview of the Committee, in addition to the wider progress against all audit actions, in quarter. Overall, the organisation continues to demonstrate a strong and improving approach to audit action management.

Internal Audit Actions

2. At the start of Quarter 2, there were 95 open internal audit actions overall, with 35 due for closure in quarter. Directorate engagement remained high and 25 actions (71%) due for completion were closed, alongside four completed ahead of schedule, resulting in 29 closures in total.
3. Timeliness of completion:

    - 45% were completed by their original deadline (down from 70% in Q1).
    - 31% met their first revised deadline (similar to Q1).
    - 24% were completed by their second revised deadline, demonstrating positive catch-up progress.

4. Of the 66 actions remaining open, 71% are scheduled for completion in Quarters 3 and 4.

5. Notably, as of July 2025, only 5.5% of the Trust's audit recommendations were open or overdue, significantly lower than the 14% Health Board average, reflecting a strong compliance culture.

6. Several actions now require or have received final revised dates. Key delays relate to technical dependencies, capacity constraints, and external supplier issues. Directors responsible for these actions have been invited to discuss progress and mitigation.

7. The single Internal Audit ARAC-related action (Risk Appetite Statements) under the purview of this committee will have been completed by the time of this meeting following Board approval in November 2025.

External Audit Actions

8. At the start of Quarter 2, there were 41 open external audit actions overall related to Audit Wales and Welsh Risk Pool reports, of which 14 were due for closure. Following evidence review:

    - Six actions were closed in quarter (29% of those due), a reduction from 45% in Q1 and 85% in Q4.
    - Two action closures were ahead of schedule.

9. The Quality Governance Follow-Up Review showed reasonable progress, with three of eight actions due being closed in quarter.

10. Progress on the Welsh Risk Pool Concerns Assessment was slightly more constrained, with two of nine actions due being completed. A number of actions required revised dates, and four actions rely on Digital automation work, which may influence future timeliness.

11. All remaining external audit actions are scheduled for completion by 31 March 2026.

Management of the Audit Tracker

12. Good governance arrangements remain in place, with clear roles for Directorate management teams, the Head of Compliance and Assurance, and the Corporate Governance Team.

13. The transition to Audit Tracker 3.0 (SharePoint) has been completed, with familiarisation and engagement activities underway. This upgrade will support better differentiation between Committee, ARAC, and Executive reporting, and improve visibility of progress through Power BI.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to:

1. **Receive assurance on** the progress made in closing audit actions during 2025/26 Quarter 2;

2. **Note** the audit actions for which final revised dates have been applied in quarter and **invite** updates from the Directors responsible for these audits.

3. **Receive assurance** that the management actions for the audits within the purview of this Committee (at Annex 2a in the Ibabs reading room*), and overall (at Annexes 1a-1f in the Ibabs reading room*), are being effectively and appropriately managed, and either closed in quarter or clarity provided on dates which have moved and rationale provided.

4. **Note** that all open audit recommendations have been transferred to Audit Tracker 3.0 and future reporting will be generated using Power BI.

*Members of the public and non-prescribed attendees can access copies of the audit tracker via the meeting papers published on the Trust website

ADDITIONAL PAPER(S)

Tracker 2.0 2025/26 Q2 (July - September 2025) – ARAC 021225 [in Ibabs reading room*]

- **Annex 1 – Full Audit Tracker (with actions shared in private session removed):**
  1a) Audit Tracker 2.0 – 25/26 Q2 Internal Audit Actions Up to 2023/24 – Full Tracker
  1b) Audit Tracker 2.0 – 25/26 Q2 Internal Audit Actions 2024/25 – Full Tracker
  1c) Audit Tracker 2.0 – 25/26 Q2 Internal Audit Actions 2025/26 – Full Tracker
  1d) Audit Tracker 2.0 – 25/26 Q2 External Audit Actions Up to 2023/24 – Full Tracker
  1e) Audit Tracker 2.0 – 25/26 Q2 External Audit Actions 2024/25 – Full Tracker
  1f) Audit Tracker 2.0 – 25/26 Q2 External Audit Actions 2025/26 – Full Tracker

- **Annex 2 – Filtered to show ARAC Audit Recommendations only:**
  2a) Audit Tracker 2.0 – 25/26 Q2 Internal Audit Actions Up to 2023/24 – ARAC only

  *Members of the public and non-prescribed attendees can access copies of the audit tracker via the meeting papers published on the Trust website

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment	N/A [DPIA Checklist > DPIA not indicated]

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
04 November 2025	Quality, Patient Experience and Safety Committee
13 November 2025	People and Culture Committee
18 November 2025	Finance and Performance Committee
19 November 2025	Director of Corporate Governance/Board Secretary
02 December 2025	Audit Risk and Assurance Committee – Private

SITUATION

1. This paper provides the Committee with an update on the current position regarding management actions for audits within the purview of the Audit, Risk and Assurance Committee (ARAC), alongside a broader progress overview for the quarter, for oversight. Copies of the Audit Tracker are available in the Ibabs reading room*:

   Annex 1 – Full Audit Tracker (with actions shared in private session removed)
   Annex 2 – Filtered to the actions under the purview of this Committee

   *Members of the public and non-prescribed attendees can access copies of the audit tracker via the published meeting papers on the Trust website.

BACKGROUND

2. In September 2023, the Audit Committee approved the Audit Process and Reporting Handbook which was subsequently revised to incorporate content from Audit Wales.

3. The Handbook includes roles and responsibilities of key stakeholders including:

   - **Directorate Points of Contact:** Points contact are responsible for progressing audit actions for their respective directorate with the Director and Assistant Directors/Deputies, ensuring that audit actions are included on the monthly directorate meetings, recording updates on the tracker, and escalating concerns where appropriate.

   - **Assistant Directors Leadership Team (ADLT):** The ADLT functions as the forum for approving the closure of audit actions, undertaking a 'check and challenge' role.

   - **Board Committees:** Committees are responsible for receiving relevant audit reports and monitoring progress of associated management actions to address audit recommendations.

   - **Audit, Risk and Assurance Committee (ARAC):** The ARAC scrutinises the progress of audits recommendations overall and escalates to the Board any issues or concerns.

4. Board committees (Quality, Patient Experience and Safety Committee; Finance and Performance Committee; and the People and Culture Committee) have each recently reviewed updates against audit actions under their purview.

5. These reviews are noted in the Committees' Assurance, Advice and Alert (AAA) reports to Board. No issues have been escalated to the Board to date.

ASSESSMENT

Internal Audit: - Full Tracker Review (**Annex 1a – 1c**)

6. During Quarter 2 there were a total of 95 open audit actions overall on Audit Tracker 2.0, with 35 of these due for closure in quarter. A high level of engagement with directorates on audit updates for 2025/26 Quarter 2 was maintained throughout the period. As a result, of the total 35 open internal audit actions due for closure in quarter.

7. Of these 35 actions due for closure in quarter, 25 (71%) were reported as completed, plus a further four actions which were not due until Quarter 3 but completed earlier than expected.

8. The table below provides a breakdown of the total 29 audit actions closed in quarter, and whether they achieved their original agreed deadline or were completed after one or more revised date.

Year	No. Actions Closed in Quarter (Q2)	Date Completed			
		Original Deadline	1st Revised Date	2nd Revised Date	3rd Revised Date
2022/23	1	0	0	1	0
2023/24	5	0	3	2	0
2024/25	23	13	6	4	0
Totals	**29**	**13**	**9**	**7**	**0**
% of Total Closed in Quarter		**45%**	**31%**	**24%**	**0%**

9. Whilst this indicates a reduction in the percentage of audit actions completed by their original deadline (70% for Q1, compared to 45% for Q2) it is difficult to compare quarters in terms of progress given the varied number and complexity of actions. However, the fact that more are being closed by their original deadline in quarter indicates realistic dates are being set when management actions are

agreed. he percentage of audit actions completed by their 1st revised date remains consistent with 30% closed in Q1, and 31% closed in Q2. It is also positive to note that seven audit actions (24%) that were on their 2nd revised date were closed in quarter.

10. As shown in the table below, the majority of the remaining open internal audit actions, i.e. 47 of the remaining 66, which equates to 71%, are scheduled to be completed during Quarters 3 and 4 (between October 2025 and March 2026); with 15 audit actions (23%) due for completion in the first two quarters of 2026/27; one (2%) not due until March 2027, and completion dates to be agreed for the remaining three actions.

Year	Total No. of Remaining Open Actions (Q2)	Due for Closure During FY & Quarter						Date TBA
		2025/26		2026/27				
		Q3	Q4	Q1	Q2	Q3	Q4	
2022/23	2	0	0	1	0	0	0	1
2023/24	7	2	0	4	1	0	0	0
2024/25	42	23	11	0	6	0	0	2
2025/26	15	4	7	3	0	0	1	0
Totals	**66**	**29**	**18**	**8**	**7**	**0**	**1**	**3**
% of Total Open Actions		**44%**	**27%**	**12%**	**11%**	**0%**	**2%**	**5%**

11. The projected closure rate for audit actions due in Quarter 3 (44%) and Quarter 4 (27%), 71% combined, remains consistent with the strong position reported in the previous period. Directorates have confirmed their commitment to delivering against these targets, and plans are in place to maintain progress despite the recognised pressures associated with major organisational programmes (such as Clinical Model Transformation and Ambulance Performance) and seasonal pressures during the winter period. While these factors may require continued close oversight, current trajectories indicate that delivery remains achievable to ensure mitigations are in place.

12. Recent discussions with Internal Audit colleagues, and review of the Internal Audit Database, indicates that (as of July 2025), 5.5% of the Trust's audit recommendations were open/overdue, compared to a combined Health Board average of 14%. This is extremely positive, and reflective of the Trust's commitment and proactive approach to implementation of audit recommendations to reduce identified risks.

Actions with Revised Dates

13. At the meeting in September 2025, this committee was informed of 12 open audit actions which had been assigned final revised dates during Quarter 1. Of these, two actions (Action Ref: 701 ~ Clinical Audit, and Action Ref: 038-24/25 ~ Exposure to Fumes) were due for closure during Quarter 2 – both have been confirmed as completed and closed in quarter.

14. Of the remaining 10 audit actions for which final revised dates were assigned during the previous quarter: four are scheduled for closure in Quarter 3 (September-December 2025), one in Quarter 4 (by the end of March 2026), and four are due to be completed in 2026/27 Quarter 1 (by the end of April 2026).

15. Of the 95 open internal audit actions updated during Quarter 2, following review, a total of 14 (15%) have been assigned **revised dates in quarter**, with a further three action completion dates to be advised – this shows a gradual and sustained downwards trend as shown in the table below.

	24/25 Q2	24/25 Q3	24/25 Q4	25/26 Q1	25/26 Q2
% Open Actions with New Revised Dates Applied in Quarter	29%	28% ↓	22% ↓	22% →	15% ↓

16. Of these 14, there are seven open internal audit actions that have been assigned **final revised dates** this quarter, or for which final revised dates are required – as shown in the table below.

Year	Audit Action Ref.	Priority Level	Internal Audit Title	Directorate	Original Deadline	Revised / Final Deadline
2022/23	621b	Medium	Technical Resilience	(Reported in private meeting)		
2022/23	656a	High	Records Management	Digital	Sep-24	**TBA**
2023/24	686	High	Electronic Patient Care Records (ePCR): Clinical Compliance	Digital	Sep-24	Apr-26

2023/24	691	Medium	ICT Contract Management	Digital	Mar-25	Sep-26
2024/25	015-24/25	High	Resourcing Policy	Operations	Mar-25	Sep-26
2024/25	048-24/25	Medium	Patient Experience & Community Involvement	Quality & Nursing	Mar-25	Mar-26
2024/25	064-24/25	Medium	Occupational Health & Wellbeing	People & Culture	May-25	Sep-26

17. The Directors responsible for the above actions have been asked to attend this committee to confirm that the revised timelines are achievable and to outline progress being made to address the risks identified in the particular audit recommendations:

17.1 The **2022/23 audit action 621b** is reported in the private meeting of this committee.

17.2 **Audit action 656a from the 2022/23 internal audit on Records Management** relates to formal arrangements for the storage of records in the space at Denbigh County Council (DCC). Potential alternative storage at Vantage Point House (VPH) has been surveyed in March and May 2025 but no suitable space identified. Instead, retention dates of the records stored at DCC have been reviewed and are routinely requested to be disposed, for which receipts are provided – this is steadily reducing the volume of records in storage, and, as this number becomes more manageable, the boxes will be moved securely to VPH. In the meantime, a formal agreement to continue storing records at DCC remains, and a copy of DCC's policies and procedures requested. The action was originally due for completion by the end of September 2024, in Quarter 4 a second revised date of July 2025 was applied. At the end of Quarter 2 the actions remains outstanding – **further revised date is to be confirmed**.

17.3 **Audit action 686 from the 2023/24 internal audit on Electronic Patient Clinical Records: Clinical Compliance (ePCR)** relates to development of the tenant structure at both a team and individual level to assist identifying training needs and drive improvement in ePCR compliance. The clinical tenant structure is complete; however, the Operations Directorate requested a structure aligned to the Duty Operational Manager (DOM) teams. Further work is therefore required on the portal frontend to allow the movement of

team members. The audit action was initially due by the end of September 2024, and in Quarter 1 (following discussion with Internal Audit colleagues) a 2nd revised date of September 2025 was applied. At the end of Quarter 2, a **3rd revised date of April 2026** has been recorded to bring this action in line with the other three remaining actions related to this internal audit.

17.4 **Audit action 691 from the 2023/24 internal audit on ICT Contract Management** relates to the contract management process being applied to all ICT contracts. In Quarter 1 it was reported that work was ongoing to adopt the process into all contracts, but this had been delayed due to extensive work being undertaken in 111 contractual agreements. At the end of Quarter 2, a 2nd revised date of March 2026 was initially proposed. However, in view of the volume of work concluding ongoing contract renewals and finalisation, this has been extended to September 2026. The Digital Directorate is considering additional resources to accelerate adoption of this action to meet the recommendation and mitigate the identified risk. The audit action was initially due by the end of March 2025, and a **2nd revised date of September 2026** has now been recorded**.**

17.5 **Audit action 015-24/25 from the 2024/25 internal audit on Resourcing Policy** relates to functional standard operating procedures (SOPs) being completed, approved, and communicated to all staff. Work has commenced on the changes, of which there are five specific areas to be agreed, including TOIL which is currently in the pilot stage. The audit action was initially due by the end of March 2025. In Quarter 4 a 1st revised date of September 2025 was applied. As part of the Quarter 2 update, a **2nd revised date of September 2026** has been recorded – this is to allow sufficient space and capacity for the Operations Directorate to engage with Trade Union Partners on the changes.

17.6 **Audit action 048-24/25 from the 2024/25 internal audit on Patient Experience and Community Involvement (PECI)** relates to increasing survey responses to provide a level of assurance that the responses received reflect the views of the public. To this end the PECI Team was liaising with the Fleet Department to explore use of QR codes on vehicles to enable patients/families to access feedback surveys whilst waiting. A paper is to be submitted to the Fleet SOP Delivery Group to obtain formal approval for this proposal. The audit action was initially due by the end of March 2025. In Quarter 4 a 1st revised date of July 2025 was applied. To allow time for development and approval of the paper, a **2nd revised date of March 2026** has been recorded.

17.7 **Audit action 064-24/25 from the 2024/25 internal audit on Occupational Health and Wellbeing** relates to enhancing occupational health performance data using All Wales key performance indicators (KPIs) to monitor areas such as needlestick injuries, immunisation reviews, and other clinical activities. The enhanced Occupational Health and Wellbeing report has been implemented for monthly monitoring of service KPIs. However, the reporting system has experienced some technical issues that currently prevent full extraction of the data required. A partial report is currently available; however, this does not fully capture all the KPIs. During the People and Culture Committee on 13 November 2025, the Director of People reported that the supplier had been made aware of the technical issue, and they had advised it could take up to six months to resolve. The Occupational Health Team therefore need to consult with the national group to understand the outcome on a system level. In the absence of a concrete timeframe for repair, the Trust will plan to implement a local solution. The action was initially due to be completed by the end of May 2025, and a 1st revised date of September 2025 was applied during Quarter 1. In view of the delay described above, which is out of the Trust's control, a **2nd revised date of September 2026** has been recorded.

Internal Audit: ARAC-specific Actions (Annex 2a in reading room)

18. In Quarter 2, there was one open internal audit actions which fell under the purview of this committee:

18.1 **Audit action 596 from the 2022/23 internal audit on Risk Management** relates to development of formal Risk Appetite Statements (RAs) and was originally due for closure in June 2024. At the end of Quarter 1, it was on its second revised date of July 2025, notwithstanding the sessions held with the Board to develop the RAs during this time and the progress made on this work. The Strategic Transformation Board considered all six RAs at its meeting on 11 August 2025. These RAs were presented to ARAC on 04 September 2025 and shared with Board at Development Session on 19 September 2025 to agree and set the appetite against each of the Trust's six strategic objectives. These were presented to the Trust Board on 27 November 2025 for formal approval, and the implementation plan is on the agenda for this committee today (2 December 2025). **Action completed.**

External Audit: - Full Tracker Review (Annexes 1d-1f in reading room)

19. At the beginning of Quarter 2, there were a total of 41 open external audit/review actions relating to the following:

Audit Year	Audit Title	No. of Recommendations
2023/24	Audit Wales: Review of Costing Savings Arrangements	1
2023/24	Audit Wales: Quality Governance Follow Up Review	8
2024/25	Welsh Risk Pool: Concerns Assessment 2024	30
2024/25*	Audit Wales: Unscheduled Emergency Care (UEC) Arrangements for Management Demand – WAST	2

**Report dated April 2025 and received later in the year, therefore recommendations are recorded under External Audit 2025/26*

20. Of the 41 open external audit actions recorded at the start of Quarter 2, 14 (34%) were due for closure in quarter, compared to 22 (43%) the previous quarter.

21. Following verification of evidence, six audit actions were confirmed as completed and closed in quarter. However, this comprised of four actions due in quarter (29%), and two actions completed earlier than planned.

22. The 29% closure rate of external audit actions during Quarter 2 is a significant decrease compared to the 45% reported in Quarter 1 and the 85% reported as closed in Q4, and is on par with the position in early 2024/25, i.e. 29% reported in Quarter 3, and 28% in Quarter 2.

2023/24 - Review of Cost Saving Arrangements

23. The single open external audit action related to the Review of Cost Saving Arrangements audit was completed within its original date of August 2025.

2023/24 - Quality Governance Review Follow-Up Audit (October 2024)

24. The eight open audit recommendations from the 2023/24 Quality Governance Review Follow-Up Audit (October 2024) were reviewed by the Quality, Patient Experience and Safety Committee on 04 November 2025.

25. Three of the eight open actions relating to this audit were confirmed as closed in quarter: two actions due by the end of September 2025 were completed by their original date and confirmed as closed in quarter; along with one further action not due until December 2025 (2025/26 Quarter 3) but was completed early.

2024/25 - Welsh Risk Pool (WRP): Concerns Assessment 2024

26. At the beginning of Quarter 2, there were a total of 30 recommendations from the Welsh Risk Pool (WRP) Concerns Assessment 2024, 9 of which were due to completed in quarter.

27. A total of two actions were closed in quarter: one action due for completion (closed by its original deadline of September 2025), and the other completed in advance of its 1st revised date (December 2025).

28. Revised dates were applied to the other eight audit actions due in quarter: seven 1st revised dates and one 2nd revised date.

29. In addition, there are four actions which are dependent upon Digital priorities/automated extraction work.

30. The remaining 24 open external audit actions are all due during Quarters 3 and 4 (all for completion by 31 March 2026) – as shown in the table below.

	No. Actions Completed in Q2	No. Actions Scheduled for Completion By Quarter		Dates TBC (Depending on Digital)
		25/26 Q3	25/26 Q4	
No. Open WRP Actions	2	9	15	4

External Audit: – ARAC Actions

31. At the start of Quarter 2, there were no open external audit actions in the purview of this committee.

Management and Development of the Tracker

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

33. The Head of Compliance and Assurance oversees Tracker updates, liaising and providing advice to directorates, validating closure evidence, following this the Corporate Governance Team formally reports progress against the tracker to Committees.

34. All audit actions which remain open at the end of Quarter 2 have been transferred to the Audit Tracker 3.0 (SharePoint solution). Engagement with internal stakeholders regarding use of Audit Tracker 3.0 is underway, and a familiarisation session with Internal Audit colleagues is also planned.

35. The current version of the tracker is now open for Directorate review for actions due between October and December 2025. These 2025/26 Quarter 3 updates will be presented to this Committee in March 2026.

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

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

    (a) Number of substantial/reasonable/limited/no assurance/advisory audit reports per year.
    Gives a general overview throughout the year and over audit years.

    (b) Number of audit reports per committee oversight
    Gives a general overview of the spread of oversight of audit reports and those who may not be monitoring any reports.

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

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

(d) *Number of actions for limited assurance audit reports more than 3 months past their original date*
Due to the issues that will arise in a limited assurance report they should be closed off asap and before follow-up reviews. This will allow for escalations.

(e) *Number of actions that have 'met' and 'not met' the original due date*
Gives an indication of the realistic nature of the original dates leading to a change in behaviour
Provides oversight of progress over audit years.
This may be similar as the table at paragraph 6 above.

(f) *Number of individual actions that have 'not met' revised dates*
Will indicate a potential issue in meeting an action or lack of progress for some other reason. Will need to be sure this is not a double count with some of the other metrics.

RECOMMENDATION(s)

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

NEXT STEPS

39. The Corporate Governance Team will:

1. Continue to work closely with Directorate points of contact to progress updates on the open audit recommendations;

2. Implement Audit Tracker 3.0 and engage with key stakeholders to provide guidance on this; and

3. Develop Power BI reporting for the key performance indicators agreed, in readiness for audit reporting at the end of Quarter 3 (December 2025).

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

Agenda Item No.	10

REPORT TITLE

Policy Report – Progress Against 2025/26 Policy Work Programme

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	02 December 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Lisa Trounce, Head of Compliance and Assurance

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This paper provides the Audit, Risk and Assurance Committee (ARAC) with an overview of the current position on Trust-owned policies and progress against the 2025/26 Policy Work Programme.

2. The Trust's policy process will be reviewed in 2026/27 and the current Policy for the Development, Review and Approval of Policies which is out of date will be updated to support this. The elements of the project have been scoped and some QI and project support secured for early in 2026/27. Further details will come back to this committee at that time.

3. This comprehensive improvement programme is designed modernise and streamline the policy framework, including clarifying which policies require Board approval versus those approved through appropriate delegations.

Governance and Current Position

4. The Policy Group reports to the Executive Leadership Team (ELT) via the AAA reporting route. The existing approval pathway varies according to the scale of policy change, with minor amendments approved by Policy Group and substantial or new policies requiring Trust-wide consultation and committee (or Board) approval.

5. At the start of 2025/26 there were 80 Trust-owned policies, with 12 new policies proposed – therefore a total of 92. Of these, 36 policies were in-date, with a further seven progressing through approval in Quarter 3, resulting in a compliance rate of 53.75%, a significant improvement from the 14% reported in 2023. NHS All Wales policies (32 in total) are monitored but sit outside the Trust's work programme.

2025/26 Policy Work Programme – Progress and Challenges

6. Directorates have prioritised their policy requirements based on risk and capacity, recognising the organisational impact of major transformation programmes, including Clinical Model Transformation. This approach initially identified 62 policies requiring development or review during the year.

7. Following prioritisation and subsequent adjustments, including deferrals and removals, 47 policies remain within the 2025/26 programme. The original end-of-year compliance forecast of 95% was adjusted to 85% in June 2025 due to emerging pressures and remains under review.

8. To-date, 18 policies have been approved or are progressing through approval in Quarter 3. However, a significant number of policies planned for Quarters 1 and 2 have been postponed due to operational pressures, capacity challenges, sickness absence, and recruitment gaps. As can be seen in Appendix 1 there are a number of policies projected for Policy Group meetings in Q3 and Q4. Whilst many of these will be approved via the Policy Group or a board committee in year, others – particularly new or complex/sensitive policies –

will undergo a period of consultation during Q3 and Q4, meaning their approval will tip over into 2026/27.

9. The policy programme will continue to be reported to ELT monthly and escalations made directly to Executives where the programme is off track.

Risk, Assurance and Improvement Activity

10. A Directorate Risk Register entry reflects the ongoing risk that delays to the policy programme could lead to out-of-date or inaccessible policies, potentially affecting staff decision-making, compliance, and patient safety. The current risk score is 16 (L4×C4), with a target score of 8.

11. Audit Wales' 2025 Structured Assessment highlighted policy governance as an area requiring continued focus and recommended appropriate resourcing to support compliance by January 2026. Existing resourcing within Corporate Governance is considered adequate for delivery, supplemented by short-term project and quality improvement support to scope changes to the governance framework.

12. As noted above, scoping on the policy transformation programme has begun, with a fuller project brief to be developed in Quarter 4. This programme will underpin the wider policy redesign planned for 2026/27.

Next Steps

13. Ongoing engagement with directorates to progress the 2025/26 policy programme and bring as many policies as possible into compliance.

14. Monthly reporting and escalation to the ELT.

15. Development of a Policy Transformation Programme project brief in Quarter 4 to support implementation during 2026/27.

16. Submission of the next biannual update to the Audit, Risk and Assurance Committee in March 2026.

In Summary

17. Overall, while progress has been made in improving policy compliance, capacity constraints and organisational pressures have affected delivery against the plan. Assurance mechanisms have been strengthened, and the forthcoming transformation programme will provide a long-term solution to modernise and streamline policy governance across the Trust. Where risks are identified in either design or operational delivery of a policy in audits, mitigations are put in place pending revisions of policies where necessary.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Audit, Risk and Assurance Committee is requested to:

1. **Receive Assurance** on the governance and process surrounding the current policy programme;
2. **Note** the remaining 2025/26 Policy Work Programme and trajectories

ADDITIONAL PAPER(S)

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

1. Appendix 1 – Policies on the 2025/26 Policy Work Programme

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 – 'Out of Date Policies' (as described within this paper)

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
07 November 2025	Trish Mills, Director of Corporate Governance/Board Secretary

SITUATION

1. The current Policy for the Development, Review and Approval of Policies (280319) is out of date. It has been agreed that an improvement programme is needed, therefore review of the policy has been deferred until after this take place, with a policy transformation programme planned for 2026/27.

2. The planned revision of the process in 2026/27 will propose more a streamlined approach to the approval of policies, other than those reserved to the board for approval.

BACKGROUND

Governance

3. The Trust's Policy Group reports into the Executive Leadership Team (ELT) by way of a AAA report.

4. The policy approval process as it currently stands is as follows:

   - ***Minor Amends*** (existing policies) > Policy Group to approve
   - ***Reasonable Amends*** (existing policies) > ELT endorsement, then Committee approval
   - ***New Policies and Substantial Amends*** (existing policies) > Trust-wide Consultation, Policy Group review, ELT endorsement, then Committee (or for limited policies – Board) approval
   - Ability for ***Chair's Action*** for pace.

Policy Data

5. At the start of 2025/26 there were 80 existing Trust-owned policies, with a further 12 new policies proposed for development, equating to a projected overall total of 92 policies.

6. In addition, there are a total of 32 extant NHS All Wales policies featured on the Policy Tracker. These are excluded from the Policy Work Programme as we have no control over the timing of their development or review.

7. There are currently 36 Trust-owned policies within review date compliance, with a further seven policies going through approval during Quarter 3, which will then equate to a total of 43 policies within their review date. This is a compliance rate of **53.75%** (up from 14% reported in 2023).

ASSESSMENT

2025/26 Policy Work Programme

8. A significant amount of work was undertaken during 2024 to improve policy review compliance, and it is recognised that those policies which remained outstanding were the more complex and challenging ones.

9. In view of the high priority transformational changes underway across the organisation, e.g. Clinical Model Transformation, and the impact that this would have on capacity, a different approach was adopted to develop the 2025/26 Policy Work Programme. Instead of being prescriptive about when policies should be reviewed and submitted to Policy Group, ADLT members were asked to take the list of policies back to their respective directorates, assess the associated risks and capacity within their teams, then advise on the priority of each policy and when they would be able to bring these to Policy Group.

10. There were initially a total of 62 policies identified for development or review in year. However, during the prioritisation process, eight policies (six Digital, one QSPE, and one P&C) were deferred to 2026/27, reducing the programme to 54 policies.

11. The 2025/26 Policy Work Programme was subsequently reviewed and agreed by both the ADLT and ELT in May 2025. The remaining policies were prioritised and the majority scheduled to come to Policy Group during Quarters 1 and 2 to avoid Winter pressures.

12. It was initially predicted that 95% of policies would be within review date compliance by end of year (31st March 2026). Given the number of policies (54 in total, equating to an average of five per month), coupled with the commitments received from directorates, at that time this target felt reasonable and achievable.

13. Since commencement of the programme, a further five policies (three QSPE, one Corporate Governance, and one Digital) have been deferred to 2026/27 () and two have been removed (one new policy no longer required, and one existing policy superceded by an All Wales policy). This leaves 47 policies to be processed in-year – as shown in the table below:

Description	No. Policies
No. of Policies (new/review) identified at the start of 2025/26	62
Less Policies Deferred to 2026/27 (8 during prioritisation + 5 post prioritisation)	13
Less Policies Superceded by All Wales Policy	1
Less Proposed New Policies No Longer Required	1
Total No. Remaining Policies to be Progressed During 2025/26	**47**

14. In view of this further shift, the update supplied to the Audit, Risk and Assurance Committee (ARAC) in June 2025 reported an adjusted trajectory of 85%, with agreement that this would be reviewed again in Quarter 3.

15. To-date, since May 2025, a total of 18 policies have been approved or are going through approval in Quarter 3.

16. The majority of policies that were scheduled to come through Policy Group in Quarters 1 and 2 have been postponed to later meeting as a result of competing demands, capacity challenges, sickness absence and recruitment to backfill vacancies. Subsequently, policies received during Quarters 3 and 4 are unlikely to be approved by the end of year, unless they are reviews of existing policies with minor amends and can be approved by Policy Group. However, this is difficult to predict and therefore the end of year trajectory is at present uncertain.

17. A list of the 29 Trust-owned policies which remain outstanding on the 2025/26 Policy Work Programme, plus details of any deferral, is contained in **Appendix 1.**

18. The Corporate Governance Team continues to work closely with directorates and policy leads to progress review of existing and development of new policies required, and to coordinate these activities around the significant programmes of work currently underway involving teams across the organisation.

19. Whilst the policy approval process has been streamlined to help facilitate policies come through and increase our compliance, the overall process is to be reviewed – the Corporate Governance Team plans to scope an improvement programme and develop a project brief in Quarter 4, with a view to implementing a policy transformation programme in 2026/27.

20. The 2025 Structured Assessment supplied by Audit Wales calls out policy progress and raises a recommendation on resourcing to bring policies in-date by January 2026. Resourcing for the policy programme in the CorGov directorate, provided it remains on track, is appropriate, however some project and QI support has been agreed for 3-4 days in Q1 or Q2 as we look at material changes to the policy governance framework.

21. The Corporate Governance Team has an existing policy risk on its Directorate Risk Register which is in the process of being reviewed. The summary description of the risk is as follows:

    IF *the Trust's Policy Programme is not delivered within a reasonable timeframe.*

    THEN *there is a risk that our Policies may not be current and readily available to support staff in their decision making and deliver safe and effective services*

    RESULTING *IN potential non-compliance with legislation, inconsistency in application of practices and patient care, compromised quality standards, leading to avoidable patient harm and damage to the Trust's reputation.*

Risk Rating	Risk Score	Likelihood	Consequence
Current	16	4	4
Target	8	2	4

RECOMMENDATION

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

NEXT STEPS

23. The Corporate Governance Team will continue to work closely with directorates and policy leads to progress review / development of the remaining policies on the 2025/26 Policy Work Programme.

24. During 2025/26 Q4, the Corporate Governance Team will develop a project brief outlining the scoping and intended benefits of the planned Policy Transformation Programme to be delivered during 2026/27.

25. The next biannual report will be submitted to this Committee in March 2026.

APPENDIX 1: Policies originally on the 2025/26 Policy Work Programme [Page 1 of 3]

Policy Title	25/26 Priorities	25/26 Policy Work Programme (ADLT Agreed Date for PG Submission)	Directorate	Policy Type	Issue Date	In Progress / Stage	Updates (as of 24/11/2025)
Safer Handling Policy	1	May-25	QS&PE	Employment	01/12/20	Under review	Sep25 - Deferred to Jan26
Resourcing Policy *	1	Jun-25	OPERATIONS	Employment	01/03/14	Under Review	Deferred to Sep26
Artificial Intelligence Policy **[NEW 2025]**	2	Nov-25	DIGITAL	Corporate	New	New	Deferred to Dec25
Management of Safeguarding Allegations Policy	2	Jul-25	QS&PE	Corporate	27/02/18	Under Review	Deferred to Jan26
MPDS QA Policy	2	Jul-25	OPERATIONS	Clinical	10/01/19	Under Review	Proposed Decommission - Deferred to Dec25
High Risk Record Policy	2	Jul-25	OPERATIONS	Corporate	16/07/20	Under Review	Deferred to Jan26
Tyres and Wheels Policy	3	Aug-25	FINANCE & CORPORATE	Corporate	16/07/19	Under review	Deferred to Jan26
Vehicle Telematics Policy	3	Aug-25	FINANCE & CORPORATE	Corporate	10/05/18	Under Review	In Progress - Submission date TBA
Freedom of Information Policy	3	Sep-25	CORPORATE GOVERNANCE	Corporate	New	New	Deferred to Dec25
ePCR Policy *[previously Patient Clinical Record Policy]*	3	Jan-26	DIGITAL	Clinical	New	New	Due Jan26
Business Continuity Management Policy	3	Jul-25	OPERATIONS	Corporate	24/10/19	Under Review	Deferred to Dec25
Assessment, Failure Referral and Appeals Policy	5	Nov-25	PEOPLE & CULTURE	Employment	01/02/16	Under Review	Deferred to Jan26
Working Time Regulations Policy	6	Sep-25	PEOPLE & CULTURE	Employment	01/07/04	Under Review	Deferred to Dec25
Maternity Policy	6	Aug-25	PEOPLE & CULTURE	Employment	10/05/18	Under Review	Submission date TBA

APPENDIX 1: Policies originally on the 2025/26 Policy Work Programme (continued) [Page 2 of 3]

Policy Title	25/26 Priorities	25/26 Policy Work Programme (ADLT Agreed Date for PG Submission)	Directorate	Policy Type	Issue Date	In Progress / Stage	Updates (as of 24/11/2025)
Paternity Policy	6	Aug-25	PEOPLE & CULTURE	Employment	10/05/18	Under Review	Submission date TBA
Shared Parental Leave Policy	6	Aug-25	PEOPLE & CULTURE	Employment	10/05/18	Under Review	Submission date TBA
Access to Personal Information Policy	6	Sep-25	DIGITAL	Corporate	25/04/19	Under Review	Deferred to Dec25
Managing Families and Relatives Working Together Policy	7	Nov-25	PEOPLE & CULTURE	Employment	10/03/20	Under Review	Deferred to Jan26
Adverse Weather Conditions Policy	7	Jan-26	PEOPLE & CULTURE	Employment	05/07/18	Under Review	Deferred to Jan26
Work Experience Policy	7	Nov-25	PEOPLE & CULTURE	Employment	No dates	Under Review	Deferred to Jan26
Bursary Scheme Policy	7	Feb-26	PEOPLE & CULTURE	Employment	01/08/16	Under Review	Due Feb26
Relocation Expenses Policy **?All Wales Policy in development**	8	Mar-26	PEOPLE & CULTURE	Employment	10/01/19	Under Review	Due Mar26
Redeployment Policy	10	Jan-26	PEOPLE & CULTURE	Employment	25/02/20	Under Review	Due Jan26
Equality, Diversity & Inclusion Policy	10	Jun-25	PEOPLE & CULTURE	Employment	New	New	**ON HOLD**
NMC Revalidation and Registration	N/A	Sep-25	QS&PE	Employment - All Wales	04/09/18	Under Review	Deferred to Dec25
Study Leave Policy	N/A	Dec-25	PEOPLE & CULTURE	Employment	01/06/15	Under Review	Deferred to Jan26
Charitable Funds Policy **[New]**	N/A	Aug-25	PARTNERSHIP & ENGAGEMENT	Corporate	New	New	Deferred to Dec25 (but may be new year)
Fire Safety Policy	N/A	Aug-25	FINANCE & CORPORATE	Corporate	17/03/22	Under Review	Deferred to Jan26 to align with Estates Internal Audit.

APPENDIX 1: Policies originally on the 2025/26 Policy Work Programme (continued) [Page 3 of 3]

Policy Title	25/26 Priorities	25/26 Policy Work Programme (ADLT Agreed Date for PG Submission)	Directorate	Policy Type	Issue Date	In Progress / Stage	Updates (as of 24/11/2025)
Command Policy	N/A	Feb-26	OPERATIONS	Corporate	25/04/23	Under Review	Due Feb26
Policy for the Development, Review and Approval of Policies	8	Mar-26	CORPORATE GOVERNANCE	Corporate	28/03/19	Under Review	**Policy Transformation - Deferred to 2026/27**
Confidentiality and Code of Conduct	N/A	**2026/27**	DIGITAL	Corporate	23/02/21	Under Review	Deferred to 2026/27
Adverse Incident/Hazard Reporting Policy	N/A	**(Routine Review due Apr25) Now 2026/27**	QS&PE	Clinical	25/04/23	Under Review	Deferred to 2026/27
Putting Things Right Policy	N/A	**(Routine Review due Apr25) Now 2026/27**	QS&PE	Corporate	25/04/23	Under Review	Deferred to 2026/27
Management of Compensation Claims Policy	6	**(O/S Review due Aug25) Now 2026/27**	QS&PE	Corporate	26/02/19	Under Review	Deferred to 2026/27
Bring Your Own Device (BYOD) Policy	4	**(Originally Expected Dec25) Now 2026/27**	DIGITAL	Corporate	New	New	Deferred to 2026/27
Information Sharing Policy	4	**2026/27**	DIGITAL	Corporate	New	New	Deferred to 2026/27
Information Governance Policy	4	**2026/27**	DIGITAL	Corporate	25/10/18	Under Review	Deferred to 2026/27
Trust Mobile Phone Policy	5	**2026/27**	DIGITAL	Corporate	01/11/09	Under review	Deferred to 2026/27
Access Control Policy	8	**2026/27**	DIGITAL	Corporate	25/10/18	Under Review	Deferred to 2026/27
Information Classification Policy	9	**2026/27**	DIGITAL	Corporate		Under Review	Deferred to 2026/27
Quality Assurance Framework for the Clinical Desk		**2026/27**	OPERATIONS	Clinical	01/06/15	Under Review	Deferred to 2026/27
Transgender Policy **[?NEW 2026]**		**2026/27**	PEOPLE & CULTURE	Employment	New	New	Deferred to 2026/27

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

Agenda Item No. 11

REPORT TITLE

Losses and Special Payments – Payments for the period 1 April – 31 October 2025

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	2 December 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Edward Roberts, Acting 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 seven months from 1st April 2025 to 31st October 2025
2. Total net Losses and Special Payments made were as follows: - 1st April 2025 to 31st October 2025 -£1.918

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: 1. Annex 1 - Losses Special and Payments 2025-26

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
N/A

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
2 December 2025	Audit Risk and Assurance Committee

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 seven months from 1 April 2025 to 31 October 2025 (Annex 1).

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2025 to 31st October 2025 amounted to -£1.918 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 seven months to 31st October 2025 reimbursements received exceeded payments made by £1.918m.

5. During August 2025 you will note a negative balance of -£0.019m for Damages, this is due to a miscoding in relation to vehicle damages refunded from a third-party insurance which has been corrected during the year.

6. During September 2025 you will note the WRP Refunds shows a balance paid to WRP as opposed to reimbursed. This payment relates to 2 cases, 1 of which is related to a CRU refund which was repayable to WRP and the other related to VAT which had been recovered and was therefore repayable to WRP.

7. During October 2025 you will note the CRU balance is showing a small negative, this is due to a refund received from CRU following a successful appeal.

RECOMMENDATION

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

NEXT STEPS

9. 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 seven months to 31st October 2025

	£
April 2025	-£1,314,358.67
May 2025	£66,430.59
June 2025	-£649,094.89
July 2025	£85,183.56
August 2025	£18,692.24
September 2025	£64,838.74
October 2025	-£189,746.31
November 2025	-
December 2025	-
January 2026	-
February 2026	-
March 2026	-
	-£1,918,054.74

Losses and Special Payments Breakdown:

Payment Type	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
	£	£	£	£	£	£	£	£	£	£	£	£	
Claimants Solicitor Costs	139,680.80	50,036.56	141,100.00	58,600.00	4,318.00	3,200.00	7,972.00	0.00	0.00	0.00	0.00	0.00	404,907.36
Counsel fees	3,570.00	750.00	28,575.00	3,996.45	5,410.00	500.00	3,380.00	0.00	0.00	0.00	0.00	0.00	46,181.45
CRU	0.00	-2,412.50	5,177.00	913.00	3,636.00	0.00	-1,517.00	0.00	0.00	0.00	0.00	0.00	5,796.50
Damages	15,375.00	2,241.00	149,910.00	500.00	-19,229.33	22,649.33	40,474.15	0.00	0.00	0.00	0.00	0.00	211,920.15
Defence Costs	12,678.08	-5,327.38	8,773.00	7,505.53	3,956.46	4,942.83	9,500.00	0.00	0.00	0.00	0.00	0.00	42,028.52
Expert Witness	11,405.00	2,930.00	7,490.00	7,500.00	2,900.00	6,210.00	4,647.80	0.00	0.00	0.00	0.00	0.00	43,082.80
Vehicle Repairs	21,074.64	18,212.91	20,240.59	6,168.58	23,651.11	23,155.08	26,413.30	0.00	0.00	0.00	0.00	0.00	138,916.21
WRP Refund	-1,518,526.19	0.00	-1,020,108.43	0.00	-7,520.00	3,496.50	-282,885.45	0.00	0.00	0.00	0.00	0.00	-2,825,543.57
Property Repairs	395.00	0.00	9,747.95	0.00	1,570.00	685.00	2,268.89	0.00	0.00	0.00	0.00	0.00	14,666.84
Court Refund	-11.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-11.00
Total	**-£1,314,358.67**	**£66,430.59**	**-£649,094.89**	**£85,183.56**	**£18,692.24**	**£64,838.74**	**-£189,746.31**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**-£1,918,054.74**

22RT4PI0006

Welsh Ambulance Services University NHS Trust	Key	
Losses and Special Payments	MN	Medical Negligence
	PI	Personal Injury
Summary of payments for the seven months to 31st October 2025	DP	Damage To Property
	£	
DP cases < £1,000	15,224.89	39 Cases
Redress cases < £1000	2,443.00	4 Cases
PI cases < £1000	5,234.00	8 Cases
26RT4MN0006	31.57	
26RT4MN0010	50.00	
26RT4MN0008	58.13	
25RT4MN0030	66.01	
26RT4MN0007	79.59	
26RT4MN0001	130.78	
26RT4MN0009	168.32	
25RT4MN0020	410.00	
25RT4MN0016	700.00	
25RT4MN0018	913.00	
24RT4PI0009	1,000.00	
26RT4GN0002	1,000.00	
24RT4GN0020	1,000.00	
26RT4EG0006	1,000.00	
26RT4EG0011	1,000.00	
22RT4PI0006	1,031.00	
26RT4DP0051	1,077.60	
26RT4EG0014	1,080.00	
25RT4MN0023	1,110.00	
26RT4DP0001	1,120.00	
26RT4DP0046	1,177.70	
22RT4MN0003	1,200.00	
26RT4DP0043	1,214.46	
24RT4PI0033	1,250.00	
25RT4EG0024	1,250.00	
26RT4EG0017	1,250.00	
26RT4DP0032	1,259.95	
22RT4PI0006	1,267.77	
25RT4MN0022	1,275.00	
26RT4DP0059	1,397.64	
26RT4DP0075	1,438.48	
26RT4DP0004	1,466.54	
24RT4PI0008	1,500.00	
26RT4EG0004	1,500.00	
25RT4MN0017	1,500.00	
26RT4EG0019	1,500.00	
26RT4DP0060	1,570.00	
22RT4GN0042	1,600.00	
24RT4GN0040	1,600.00	
23RT4GN0013	1,600.00	
22RT4GN0032	1,600.00	
24RT4GN0043	1,600.00	
26RT4DP0062	1,630.00	
24RT4PI0041	1,663.00	
26RT4DP0009	1,668.23	
26RT4DP0087	1,727.14	
26RT4DP0011	1,759.34	
26RT4DP0085	1,776.21	
26RT4DP0082	1,813.39	
19RT4PI0033	1,828.00	
26RT4DP0029	1,848.31	
22RT4MN0003	1,850.00	
26RT4DP0037	1,875.50	
23RT4GN0020	1,920.00	
26RT4DP0057	1,928.07	
26RT4DP0074	1,970.80	
26RT4EG0012	1,996.45	
23RT4MN0021	2,000.00	
26RT4GN0001	2,000.00	
26RT4EG0007	2,000.00	
26RT4DP0064	2,018.22	
26RT4DP0079	2,021.16	
26RT4DP0023	2,059.16	
26RT4DP0006	2,246.39	
26RT4EG0008	2,250.00	
26RT4DP0088	2,268.89	
26RT4DP0077	2,281.72	
26RT4EG0003	2,382.05	
26RT4DP0067	2,404.14	
25RT4MN0021	2,430.00	
24RT4MN0015	2,560.00	
24RT4GN0034	2,590.00	
26RT4DP0056	2,647.79	
26RT4DP0019	2,687.30	
26RT4DP0044	2,700.00	
22RT4PI0018	2,745.00	
26RT4DP0008	2,745.16	
26RT4DP0017	2,750.00	
26RT4DP0018	2,750.00	
26RT4DP0033	2,808.00	
26RT4DP0086	2,812.54	
25RT4EG0026	2,950.00	
26RT4EG0020	2,950.00	
23RT4MN0002	2,976.00	
26RT4DP0066	2,978.15	
26RT4DP0054	3,106.55	
26RT4DP0022	3,108.53	
26RT4DP0031	3,170.92	
26RT4DP0076	3,251.65	
19RT4PI0031	3,274.00	
26RT4DP0065	3,274.00	
20RT4MN0011	3,276.50	
26RT4DP0021	3,370.55	
25RT4MN0019	3,400.00	
25RT4MN0030	3,400.00	
26RT4EG0015	3,500.00	
26RT4DP0053	3,516.00	
25RT4MN0016	3,535.00	
24RT4PI0033	3,546.80	
19RT4PI0034	3,874.00	
26RT4DP0069	4,037.32	
23RT4GN0028	4,100.00	
26RT4DP0016	4,282.13	
26RT4DP0040	4,410.60	
26RT4DP0010	4,499.76	
26RT4PI0001	4,500.00	
26RT4EG0018	4,550.00	
26RT4DP0035	4,732.28	
26RT4DP0036	4,756.58	
26RT4DP0055	4,782.03	
23RT4GN0027	4,800.00	
25RT4MN0023	4,820.00	
23RT4GN0013	5,000.00	
26RT4DP0024	5,088.03	
26RT4DP0034	5,434.00	
25RT4MN0020	5,582.50	
25RT4EG0035	5,850.00	
26RT4DP0080	5,993.80	
24RT4PI0064	6,038.00	
21RT4MN0009	6,472.00	
26RT4DP0068	6,482.25	
23RT4PI0009	7,874.15	
24RT4PI0066	9,299.80	
19RT4PI0032	9,546.00	
24RT4PI0028	9,601.00	
24RT4MN0008	10,000.00	
21RT4PI0026	11,500.00	
18RT4MN0016	14,632.40	
23RT4MN0004	15,375.00	
26RT4EG0002	18,600.00	
26RT4GN0005	22,000.00	
24RT4MN0005	24,000.00	
24RT4MN0004	30,000.00	
22RT4PI0046	32,381.16	
22RT4MN0018	37,188.00	
24RT4MN0013	50,710.00	
18RT4MN0012	107,779.00	
21RT4MN0009	208,585.00	
24RT4PI0026	(80.00)	REFUND
24RT4GN0040	(300.00)	WRP REFUND
24RT4GN0031	(500.00)	WRP REFUND
24RT4GN0039	(500.00)	WRP REFUND
24RT4GN0038	(800.00)	WRP REFUND
18RT4MN0012	(829.00)	CRU Refund
23RT4GN0012	(1,000.00)	WRP REFUND
22RT4GN0042	(1,100.00)	WRP REFUND
20RT4PI0037	(2,125.00)	REFUND
24RT4GN0020	(2,375.00)	WRP REFUND
22RT4GN0037	(2,400.00)	WRP REFUND
23RT4GN0027	(3,200.00)	WRP REFUND
22RT4MN0018	(3,438.00)	REFUND
23RT4GN0020	(3,800.00)	WRP REFUND
22RT4GN0005	(3,800.00)	WRP REFUND
20RT4MN0008	(10,799.67)	WRP REFUND
23RT4GN0028	(10,910.00)	WRP REFUND
22RT4PI0006	(19,985.00)	WRP REFUND
20RT4MN0011	(22,628.90)	REFUND (incorrectly coded corrected in yr)
24RT4GN0026	(24,750.00)	WRP REFUND
21RT4PI0006	(29,450.00)	WRP REFUND
19RT4PI0037	(38,264.58)	WRP REFUND
24RT4MN0013	(75,410.00)	WRP REFUND
22RT4PI0038	(89,481.02)	WRP REFUND
22RT4PI0022	(97,409.43)	WRP REFUND
24RT4MN0009	(961,854.78)	WRP REFUND
22RT4MN0001	(1,450,963.19)	WRP REFUND
Total	**(1,918,054.74)**	

Welsh Ambulance Services University NHS Trust
Aug-25

Case Reference	Details	Amount (£)
24RT4PI0008	COUNSEL FEES	750.00
24RT4PI0033	COUNSEL FEES	3,000.00
24RT4PI0041	COUNSEL FEES	350.00
24RT4PI0041	COURT FEES	313.00
21RT4MN0009	EXPERT WITNESS	2,100.00
21RT4MN0009	EXPERT WITNESS	400.00
21RT4MN0009	EXPERT WITNESS	400.00
25RT4MN0016	COUNSEL FEES	200.00
25RT4MN0023	COUNSEL FEES	1,110.00
26RT4MN0006	TRANSCRIPTION COSTS	31.57
26RT4MN0007	TRANSCRIPTION COSTS	53.76
26RT4MN0008	TRANSCRIPTION COSTS	58.13
26RT4DP0046	TP VEHICLE REPAIRS	47.14
26RT4DP0008	TP VEHICLE REPAIRS	500.00
26RT4DP0023	TP VEHICLE REPAIRS	2,059.16
26RT4DP0053	TP VEHICLE REPAIRS	3,516.00
26RT4DP0054	TP VEHICLE REPAIRS	3,106.55
26RT4DP0055	TP VEHICLE REPAIRS	2,000.00
26RT4DP0056	TP VEHICLE REPAIRS	2,647.79
26RT4DP0057	TP VEHICLE REPAIRS	1,080.00
26RT4DP0057	TP VEHICLE REPAIRS	848.07
26RT4DP0058	TP VEHICLE REPAIRS	755.38
26RT4DP0008	TP VEHICLE REPAIRS	750.00
26RT4DP0060	DAMAGE TO PROPERTY	1,570.00
26RT4DP0062	TP VEHICLE REPAIRS	1,630.00
26RT4DP0064	TP VEHICLE REPAIRS	500.00
26RT4DP0064	TP VEHICLE REPAIRS	1,318.22
26RT4DP0008	TP VEHICLE REPAIRS	1,495.16
26RT4DP0059	TP VEHICLE REPAIRS	1,397.64
26RT4EG0015	PROFESSIONAL FEES	3,500.00
20RT4PI0037	GENERAL DAMAGES SETTLEMENT	- 22,549.33
22RT4PI0003	CRU	744.00
24RT4PI0064	GENERAL DAMAGES SETTLEMENT	3,320.00
22RT4PI0006	CLAIMANTS SOLICITORS FEE	2,718.00
21RT4MN0009	CRU	2,892.00
23RT4GN0013	CLAIMANTS SOLICITORS FEES	1,600.00
23RT4GN0020	WRP REIMBURSEMENT	- 3,800.00
22RT4GN0037	WRP REIMBURSEMENT	- 2,400.00
22RT4GN0042	WRP REIMBURSEMENT	- 1,320.00
Totals		**18,692.24**

Welsh Ambulance Services University NHS Trust
Sep-25

Case Reference	Details	Amount (£)
22RT4MN0018	EXPERT WITNESS	- 3,150.00
22RT4MN0018	PROFESSIONAL FEES	400.00
24RT4MN0015	EXPERT WITNESS	2,560.00
25RT4MN0016	COUNSEL FEES	500.00
25RT4MN0017	PROFESSIONAL FEES	1,500.00
25RT4MN0019	EXPERT WITNESS	3,400.00
25RT4MN0020	PROFESSIONAL FEES	410.00
25RT4MN0030	EXPERT WITNESS	3,400.00
26RT4DP0055	TP VEHICLE REPAIRS	2,782.03
26RT4EG0016	TRANSCRIPTION COSTS	34.68
26RT4EG0017	PROFESSIONAL FEES	1,250.00
26RT4DP0065	TP VEHICLE REPAIRS	3,274.00
26RT4DP0066	TP VEHICLE REPAIRS	2,978.15
26RT4DP0064	TP VEHICLE REPAIRS	200.00
26RT4DP0067	TP VEHICLE REPAIRS	47.14
26RT4DP0068	TP VEHICLE REPAIRS	1,479.68
26RT4DP0069	TP VEHICLE REPAIRS	4,037.32
26RT4DP0068	TP VEHICLE REPAIRS	5,002.57
26RT4DP0070	TP VEHICLE REPAIRS	125.90
26RT4GN0001	EX GRATIA PAYMENT	100.00
26RT4DP0028	TP VEHICLE REPAIRS	211.29
26RT4DP0067	TP VEHICLE REPAIRS	1,630.94
26RT4DP0067	TP VEHICLE REPAIRS	726.06
26RT4DP0071	DAMAGE TO PROPERTY	685.00
26RT4DP0072	TP VEHICLE REPAIRS	660.00
22RT4GN0032	CLAIMANTS SOLICITORS COSTS	1,600.00
26RT4MN0007	TRANSCRIPTION COSTS	25.83
26RT4MN0009	TRANSCRIPTION COSTS	168.32
22RT4GN0042	WPR	220.00
24RT4PI0008	COURT FEES	123.00
20RT4MN0011	WPR	3,276.50
24RT4GN0043	PROFESSIONAL FEES	1,600.00
20RT4PI0037	CORRECTION MISCODED P5	22,549.33
22RT4PI0006	REFUND CORRECTION P2	1,031.00
Totals		**64,838.74**

Welsh Ambulance Services University NHS Trust
Oct-25

Case Reference	Details	Amount (£)
24RT4PI0033	COUNSEL FEES	250.00
24RT4PI0033	EXPERT WITNESS	296.80
24RT4PI0041	COUNSEL FEES	1,000.00
21RT4MN0009	COUNSEL FEES	680.00
22RT4MN0003	EXPERT WITNESS	400.00
22RT4MN0003	COUNSEL FEES	1,450.00
23RT4MN0002	EXPERT WITNESS	2,976.00
26RT4DP0074	TP VEHICLE REPAIRS	1,970.80
26RT4DP0028	TP VEHICLE REPAIRS	181.12
26RT4DP0075	TP VEHICLE REPAIRS	1,438.48
26RT4DP0076	TP VEHICLE REPAIRS	450.00
26RT4DP0077	TP VEHICLE REPAIRS	2,281.72
26RT4EG0018	PROFESSIONAL FEES	4,550.00
26RT4EG0019	PROFESSIONAL FEES	1,500.00
26RT4DP0078	TP VEHICLE REPAIRS	583.74
26RT4EG0020	PROFESSIONAL FEES	2,950.00
26RT4DP0079	TP VEHICLE REPAIRS	2,021.16
26RT4DP0080	TP VEHICLE REPAIRS	2,595.48
26RT4DP0081	TP VEHICLE REPAIRS	47.14
26RT4DP0082	TP VEHICLE REPAIRS	1,813.39
26RT4DP0083	TP VEHICLE REPAIRS	97.30
26RT4DP0080	TP VEHICLE REPAIRS	3,298.32
26RT4EG0021	PROFESSIONAL FEES	500.00
25RT4DP0094	TP VEHICLE REPAIRS	327.11
26RT4DP0084	TP VEHICLE REPAIRS	90.00
26RT4DP0085	TP VEHICLE REPAIRS	1,776.21
26RT4DP0086	TP VEHICLE REPAIRS	2,812.54
26RT4DP0087	TP VEHICLE REPAIRS	47.14
26RT4DP0080	TP VEHICLE REPAIRS	100.00
26RT4DP0088	DAMAGE TO PROPERTY	2,268.89
26RT4DP0076	TP VEHICLE REPAIRS	2,801.65
26RT4DP0087	TP VEHICLE REPAIRS	1,680.00
24RT4MN0013	WPR	- 75,410.00
22RT4PI0022	WPR	- 97,409.43
22RT4PI0038	WPR	- 89,481.02
22RT4GN0005	WPR	- 3,800.00
23RT4GN0027	WPR	- 3,200.00
24RT4GN0020	WPR	- 2,375.00
24RT4GN0040	WPR	- 300.00
23RT4GN0028	WPR	- 10,910.00
19RT4PI0031	GENERAL DAMAGES SETTLEMENT	1,500.00
19RT4PI0031	CLAIMANT SOLICITOR FEES	1,774.00
19RT4PI0032	CLAIMANT SOLICITOR FEES	2,546.00
19RT4PI0032	GENERAL DAMAGES SETTLEMENT	7,000.00
19RT4PI0033	CLAIMANT SOLICITOR FEES	1,828.00
19RT4PI0034	CLAIMANT SOLICITOR FEES	1,774.00

19RT4PI0034	GENERAL DAMAGES SETTLEMENT	2,100.00
23RT4PI0009	GENERAL DAMAGES SETTLEMET	7,874.15
18RT4MN0012	CRU REFUND	- 829.00
22RT4MN0018	CRU REFUND	- 688.00
26RT4MN0010	CLAIMANTS SOLICITORS FEE	50.00
26RT4GN0005	GENERAL DAMAGES SETTLEMENT	22,000.00
26RT4GN0006	EXPERT WITNESS	975.00
Totals		**- 189,746.31**

Agenda Item No.	12

REPORT TITLE

Committee Priorities and Cycle of Business Monitoring Report 2025/26

MEETING

Name of meeting	Audit Risk and Assurance Committee
Date of meeting	2 December 2025
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	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. This report updates the Committee on progress against the priorities it set for 2025/26 and progress against the agreed cycle of business for the committee. In response to the 2025 Structured Assessment an adjustment has been made to the committee cycle of business. The recommendation is that late papers be formally recorded and non-compliance with the standing orders be reported, in line with Audit Wales' Structured Assessment Recommendation "to

strengthen governance and transparency, the Trust should formally record and report any Board or Committee Papers submitted after the 5-day publication deadline as a breach of its Standing Orders (Paragraph 12)".

2. During the effectiveness reviews, it was agreed that it is good practice for committees to set priorities for the forthcoming year. The committee's priorities, which are set out below, were agreed by the Trust Board in May 2025 and will be tracked quarterly.

3. The committee's cycle of business was approved by the Committee in May 2025. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

4. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports.

5. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or is an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but has been deferred to a future meeting.

6. Finally, the committee's priorities and progress against them is as follows:

Priority	Progress
• Monitoring progress of the committee effectiveness review 'part II' throughout 2025/26 (as set out at the 01 May 2025 ARAC) with respect to the committee delegations, membership and meeting frequency.	• In December 2025 the committee considered the options for the wider board committee framework changes and endorse option 1, to be deferred until the outcomes of the externally facilitated board effectiveness review are received and considered (noting this may be mid-year in 2026/27). They also approved the approach to the quality and effectiveness review for ARAC, being that the ARAC sub-group will review the NAO effectiveness toolkit and provide this and any key issues to the March 2026 meeting, alongside responses to a short qualitative survey of members. They also recommended to the board that their quality and governance review includes a repeat of the survey conducted in 2024/25.

	• A project plan was agreed with a sub-group of ARAC. The Director of Corporate Governance/Board Secretary presented a paper at the meeting of the Audit Risk and Assurance Committee on 2 September 2025 regarding the 2025/26 Effectiveness Review and has facilitated an ongoing discussion with a sub-group of ARAC regarding this work.	

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to NOTE the update.

ADDITIONAL PAPER(S)

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

The Committee is requested to receive the following:

1. Audit Risk and Assurance Committee Cycle of Business Monitoring Report December 2025.

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
2 December 2025	Audit Risk and Assurance Committee

PAPER	PRE or POST C'EE FORUM	FREQUENCY	Q1a	Q1b	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
AUDIT, RISK AND ASSURANCE COMMITTEE - CYCLE OF BUSINESS 2025/26										
For the rationale for this Committee's cycle see Note 8										
Annual filings										
Annual accounts planning and emerging issues report	ELT	Annually						EDOF	Assurance	
Annual report timetable	ELT	Annually						BS	Assurance	
Audited accounts	ELT and Board	Annually						EDOF	Endorsement	
Annual report	ELT and Board	Annually						BS	Endorsement	
Head of internal audit report and opinion	ELT and Board	Annually						Internal Audit	Assurance	
Audit report on accounts	ELT and Board	Annually						Audit Wales	Assurance	
Self-assessment against Governance Code 2017	ELT	Annually						BS	Assurance	
Internal Audit										
Audit Plan	ELT	Annually						Internal Audit	Approval	
Internal audit reports	ELT and C'ees	Quarterly						Internal Audit	Assurance	Relevant directors to be in attendance for limited assurance reviews
Audit Wales										
Audit Plan	ELT and Board	Annually						Audit Wales	Review	SFI 3.4.1 AC must ensure cost efficient external audit service is delivered; SFI 3.4.3 AC to review plan and associated costs. Noted to Board
Update report	N/A	Quarterly						Audit Wales	Assurance	
Annual Audit Report	ELT and Board	Annually						Audit Wales	Assurance	Audit report for calendar year. Copy to Board in AAA
Structured Assessment	ELT and Board	Annually						Audit Wales	Assurance	May also be presented at other times depending upon audit plan
Other Non-Core Reports	ELT and Board	Various						Audit Wales	Assurance	Non-core reports are those outside of the Structured Assessment work and are included in the Audit Plan
Losses & Special Payments/Single Tender Waivers										
Quarterly lossess and special payments report	N/A	Quarterly						EDOF	Approval	See Note 1
Tender update report and single tender waiver request	N/A	Quarterly						EDOF	Assurance	Closed session
Counter fraud										
Counter fraud update report	N/A	Quarterly						EDOF	Assurance	Closed session. See Note 6
Counter fraud annual report	ELT	Annually						EDOF	Assurance	Closed session. See Note 6 **Not to go to Board - only ARAC**
Counter fraud update work plan	ELT	Annually						EDOF	Approval	Closed session. See Note 6
Standing Orders & Standing Financial Instructions										
Standing Orders & Standing Financial Instructions	ELT and Board	Annually		→				BS	Endorsement	Q4 24-25: Revised for 2025, however SFI changes will be coming forward for Q2 ARAC 25-26.
Breach of Standing Orders & Standing Fin. Instructions	ELT	Ad Hoc						BS	Discussion/Assurance	
Non-compliance with SO: publication of late papers	**ELT**	**Quarterly**						BS	Discussion/Assurance	**061125 (AP): added in in response to SA 2025 recommendation. Reporting to begin in Q4.**
Governance Practice Notes	ELT	Annually						BS	Approval	Q1b: Review not required in 2025; reference in the monitoring report update.
Whistleblower, Declarations, Gifts & Hospitality										
Annual report on declarations of interest	ELT	Annually						BS	Assurance	
Report on gifts and hospitality	ELT	Annually						BS	Assurance	
Whistleblower (speaking up safely) report	TBC	TBC						BS	TBC	See Note 2
Other										
Near Miss Report	QUEST	Annually						BS	Assurance	See Note 3
Policy										
Policy report	ELT	Quarterly						BS	Assurance	Position on policies including those outstanding for review etc. See Note 4
Policies	Policy Group	Ad Hoc						BS	Approval	Policies within the purview of this Committee - see Note 5
Financial procedures	TBC	Ad Hoc						EDOF	Approval	SFI 1.1.3 all financial procedures must be approved by the EDOF and Audit Committee
Risk Management										
Review of risk related elements in IMTP	STB	Annually						BS	Assurance	
Board Assurance Framework	ELT	Each meeting						BS	Assurance	
Corporate Risk Register	ELT	Each meeting						BS	Assurance	
Audit Recommendation Tracker	ELT	Each meeting						BS	Assurance	
GOVERNANCE										
Escalations from Board Committees	Board Committee	Ad Hoc						Committee Chair	Various	
Committee effectiveness reviews and annual reports	All Committees	Annually						BS	Approval	Q2: 2025/26 Effectiveness Reviews - Progress and Recommendations
Audit Committee effectiveness review /annual report	Audit/Board	Annually						BS	Approval	
Audit Committee Review of Terms of Reference	Audit/Board	Annually						BS	Approval	
Audit Committee Cycle of Business annual refresh	Audit/Board	Annually						BS	Approval	
Audit Committee Review of Annual Priorities	None	Quarterly						Chair	Review	
All Wales Audit Committee Chair's Meeting Report	AWACC	Bi-annually						Chair	Review	
Mid-year review of committee operating arrangements	n/a	Annually						BS	Review	
Integrated Governance Programme Progress Update	**n/a**	**Bi-annually**						**BS**	**Assurance**	**Added on 160625**
Review of Governance Practice Notes	**n/a**	**Biennially**						**BS**	**Approval**	**Added on 100625**
PROMPTS										
External Reports	n/a	As required						TBC	TBC	

Two Q1 meetings. Q1a is a governance meeting to take the Committee annual reports and other items as noted

EDOF - Executive Director of Finance and Corporate Resources

BS - Board Secretary

Key: Pre-agenda setting

- Cycled for each meeting
- Ad hoc item - prompt for agenda setting
- Reporting developing

Key: Post-agenda setting

- Presented as cycled
- Ah hoc / item considered - not programmed
- → Item deferred
- Reporting developing

1	**Losses and special payments**	Whilst SFIs provide for approval of these, the payments are in effect already made when they are presented to the AC. All payments are made within SFI delegated limits. Further work with DOFs and Finance Academy at the next version of the SFIs to look at whether ACs should retrospectively approve such payments.
2	**Whistleblowing (SUS)**	Staff can currently raise concerns through the traditional routes of line management and escalation set out in the All Wales Procedure for Raising Concerns, and through the sensitive issues function in Datix. The Speaking Up Safely framework is overseen on behalf of the board by the People and Culture Committee. Assurance on the whistleblowing (or speaking up safely) process and arrangements for special investigations to come to Audit Committee via a AAA from the Chair of the People and Culture Committee . See pages 39 and 40 of Audit Committee Handbook
3	**Near Miss Report**	NAO effectiveness review outcomes recommends AC reviews information on 'near misses' to help determine whether the systems in place are sufficiently robust to mitigate future risk events. Assurance to ARAC via AAA from chair of QUEST annually. Audit Committee 25 July agreed that near misses would be monitored by QUEST. It noted that QUEST receives patient safety reporting which is predominantly based on the significant and catastrophic harm with moderate harm and near misses incorporated into thematic content. A more explicit near miss reporting will be developed, however there is limited capacity in the team to do so this year given the need to deal with the core requirements of national reportable incidents, Coroner requests and the Duty of Candour. Discussions in H&S Board Development 220224 on near misses. In Datix a report of no harm is categorised as a near miss so can start looking at developing that reporting. Cycled in for once per year to revisit.
4	**Policy report**	Each Committee has included in their cycles of business a report on the policies in their remit and their currency. An overarching report is being developed for this Committee's oversight.
5	**TOR 3.2 (a) The Committee will support the Board with regard to its responsibilities for governance by reviewing: the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements.**	Key corporate policies include - Counter Fraud Policy - Charitable Funds Investment Policy - Standards of Business Conduct - Whistleblowing Policy - Public Sector Payment Policy (All Wales) - Risk Policy - Data Protection Policy - Health & Safety Policy - Information Governance Policy - Information Risk Policy - Information Security Policy
6	**Local Counter Fraud**	Local Counter Fraud Specialists (LCFSs) are responsible for developing the anti-fraud, bribery and corruption culture within their respective health service areas and for investigating fraud cases within their own local health trusts and boards. The Welsh ministers and the NHS Counter Fraud Authority (NHSCFA) have entered into a service agreement under section 83 of the Government of Wales Act 2006, to ensure that appropriate provision is in place to tackle all matters connected to Fraud, Bribery and Corruption. It is the role of the LCFS to ensure regular engagement and reporting to senior members surrounding the work completed within this field, with the audit committee being recognised as an appropriate recipient to the status and developments of the service. Service strands of hold to account, prevent and deter, inform and involve, and strategic governance
8	**Cycle of Business**	The cycle has been developed to align with the duties for the Committee set out in the terms of reference. Of note, paragraph 3.5 of the terms of reference requires the Committee's programme of work to be designed to provide assurance that: a.there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee; b.there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee and ensure all reported fraud concerns and ongoing investigations are notified to the Committee; c.there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees; d.the work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity; e.the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; f.the systems for financial reporting to the Board, including those of budgetary control, are effective; g.the results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations' governance arrangements; h.progress is monitored against the requirement of the Auditors' Management Letter; i.the Committee receives and reviews key Trust Annual Reports e.g., Trust Annual Report, Infection Control Annual Quality Statement; Annual Governance Statement and make recommendations to the Board for their adoption; and j.the Committee reviews the content of the Corporate Risk Register and obtain assurance that control measures are in place to mitigate all identified risks.