Bundle Audit, Risk and Assurance Committee (Open) 2 March 2026

Agenda attachments

00 Agenda

0 09:30 - OPENING ITEMS

1 Chair's Welcome, Apologies and Quorum

2 Declarations of Interest

Item 02 Board Member Register of Interests 13 February 2026

3 Minutes of the last meeting on 2 December 2025

Item 03 2025-12-02 ARAC OPEN Minutes unconfirmed

4.1 Action Log

Item 04.1 Action Log

4.2 Committee AAA Highlight Report: 2 December 2025

Item 04.2 ARAC AAA Report 2 December 2025

4.3 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:35 - Internal Audit

5.1 Internal Audit Plan 2026/27 (approval)

Item 05.1 Internal Audit Plan 2026-27

5.2 Internal Audit Progress Report

Item 05.2 Internal Audit Progress Report March 2026

5.3 Internal Audit Reports

5.3.1 Budget Setting [Reasonable Assurance] [CT]
5.3.2 Clinical Model Transformation Programme [Reasonable Assurance] [RM]
5.3.3 Cymru High Acuity Response Unit (CHARU) [Reasonable Assurance] [AS]

Item 05.3.1 Budget Setting Final Internal Audit Report

Item 05.3.2 CMTP Final Internal Audit Report

Item 05.3.3 CHARU Final Internal Audit Report

6 10:35 - Audit Wales

6.1 Audit Committee Update

Item 06.1 Audit Committee Update (March 2026)

6.2 Annual Audit Summary 2025 [including Urgent and Emergency Care Part 3 outcomes]

Item 06.2 Annual Audit Summary 2025

6.3 2026 Outline Audit Plan (Approval)

Item 06.3 2026 Outline Audit Plan

6.4 11:20 - COMFORT BREAK

7 11:35 - ARAC 2025/26 Quality and Governance Review

Item 07 ARAC Quality and Governance Review SBAR 020326

Item 07 Annex 1 ARAC Terms of Reference 2026-27

Item 07 Annex 2 NAO Questionnaire

8 12:05 - Risk Management and Board Assurance Framework

Annex 4 is available to view in the Reading Room

Item 08 Risk Management Report

Item 08 Annex 5 - Trending Data Mar 2023 - Feb 2026

Item 08 Annex 6 - Risk Management Policy v2.2 190226

Item 08 Annex 7 - Risk Reporting Schedule 2026-27

9.1 12:20 - 2025-26 Annual Accounts Report

Item 09.1 2025-26 Annual Accounts Report

9.2 2025-26 Annual Filings Schedule

Item 09.2 2025-26 Annual Filings Schedule

Item 09.2 Annex 1 2025-26 Annual Filings Timetable

10 12:35 - Integrated Governance Programme Progress Update

Item 10 Integrated Governance Programme Report

11 12:45 - Audit Tracker 2025-26 Q3

Item 11 Audit Tracker 25-26 Q3 (Oct-Dec25)

12 12:55 – Policy Report [Including Standards of Business Conduct Policy]
- Item 12 Policy Report
- Item 12 Annex 1 Standards of Business Conduct Policy
- Item 12 Annex 2 2025-26 Policy Work Programme (as at 18.02.2026)

13 13:00 – Losses and Special Payments Report
- Item 13 Losses and Special Payments
- Item 13 Annex 1 Losses and Special Payments 2025-26

14 13:05 – Non-Compliance with Standing Orders: publication of late Papers
- Item 14 Non-compliance with Standing Orders, publication of late papers

14.1 CONSENT ITEMS

15 13:10 – Cycle of Business Monitoring Report and Priorities Update 2025-26
- Item 15 Priorities & Cycle Monitoring Report March 2026
- Item 15 Annex 1 Tab 1 Cycle of Business
- Item 15 Annex 1 Tab 2 Cycle of Business Notes

15.1 13:10 – CLOSING ITEMS

16 Reflections

17 Any Other Business

18 Date & Time of the next meeting: 28 April 2026 at 9:30am

Length of Meeting: 03:45 | **Agenda Status:**

[OPEN] AUDIT, RISK AND ASSURANCE COMMITTEE - 2 MARCH 2026

Deadline for Papers: 19 FEBRUARY 2026 | **Last good practice Exec Review:** 18 FEBRUARY 2026

Time	Mins allotted	Agendum	Title	Format	Item for	Item requested by	Paper prepared by	Item presented by	Colleagues to cc	Scheduled at ELT	Further approval route (if app.)	Notes
			OPENING ITEMS									
09:30	00:05	1	Chair's Welcome, Apologies and Quorum	Verbal	Information	Standing	n/a	Chair	n/a			
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a			
		3	Minutes of the last meeting on 2 December 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 December 2025	Paper	Discussion	Standing	n/a	Chair	n/a			
			FOR APPROVAL, ASSURANCE AND DISCUSSION									
09:35	01:00	5	**Internal Audit** 5.1 Internal Audit Plan 2026/27 (approval) 5.2 Internal Audit Progress Report 5.3 Internal Audit Reports 5.3.1 Budget Setting **[Reasonable Assurance]** [CT] 5.3.2 Clinical Model Transformation Programme **[Reasonable Assurance]** [RM] 5.3.3 Cymru High Acuity Response Unit (CHARU) **[Reasonable Assurance]** [AS]	Paper	Assurance	CoB	Internal Audit	Osian Lloyd	Felicity Quance			
10:35	00:45	6	**Audit Wales** 6.1 Audit Committee Update 6.2 Annual Audit Summary 2025 [including Urgent and Emergency Care Part 3 outcomes] 6.3 2026 Outline Audit Plan (Approval)	Paper	Assurance	CoB	External Audit	Fflur Jones	n/a			
11:20	00:15		COMFORT BREAK									
11:35	00:30	7	ARAC 2025/26 Quality and Governance Review	Paper	Endorsement	CoB	CorGov	Trish Mills	Jule Boalch, Alex Payne			
12:05	00:15	8	Risk Management and Board Assurance Framework	Paper	Assurance	CoB	CorGov	Julie Boalch	Julie Boalch			
12:20	00:15	9	9.1 2025-26 Annual Accounts Report 9.2 2025-26 Annual Filings Schedule	Paper	Approval	CoB	FinCor	Chris Turley, Ed Roberts	Jillian Gill, Lisa Trounce			
12:35	00:10	10	Integrated Governance Programme Progress Update	Paper	Assurance	CoB	CorGov	Trish Mills	Jule Boalch, Alex Payne			
12:45	00:10	11	Audit Tracker 2025-26 Q3	Paper	Assurance	CoB	CorGov	Trish Mills	Lisa Trounce			
12:55	00:05	12	Policy Report **[Including Standards of Business Conduct Policy]**	Paper	Approval	CoB	CorGov	Trish Mills	Lisa Trounce			
13:00	00:05	13	Losses and Special Payments Report	Paper	Assurance	CoB	FinCor	Chris Turley, Ed Roberts	Jillian Gill			
13:05	00:05	14	Non-Compliance with Standing Orders: publication of late Papers	Paper	Assurance	CoB	CorGov	Trish Mills	Alex Payne			
			CONSENT ITEMS									
13:05	00:00	15	Cycle of Business Monitoring Report and Priorities Update 2025-26	Papers	Information	CoB	CorGov	Trish Mills	Sarah Harland			
			CLOSING ITEMS									
13:05	00:05	16	Reflections	Verbal	Discussion	Standing	n/a	Chair	n/a			
		17	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a			
		18	Date & Time of the next meeting: 28 April 2026 at 9:30am	Verbal	Information	Standing	n/a	Chair	n/a			
13:10	**03:45**		**CLOSE**									

LEAD PRESENTERS

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

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	**Non-Executive Director**	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
	* Member of the Remuneration Committee	Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
	* Member of the the Audit, Risk and Assurance Committee	RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
	* Member of the Quality, Patient Experience and Safety Committee	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**	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
	* Chair of the Audit, Risk and Assurance Committee	Company Director - Action for Children [04764232]	Directorships	01 February 2021		
	* Chair of the Charity Committee	Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
	* Member of the Finance and Performance Committee	Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
	* Member of the Remuneration Committee	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 - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015	January 2025	
	* Chair of Remuneration Committee	Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director - Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Chair - North Devon Homes	Position in Charity or Voluntary Organisation	01 October 2021	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**	Chief Executive Officer (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
	* Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee	Non-Executive Board Member at Beacon Housing (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
	* Member of People & Culture Committee	Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
	* Member of Remuneration Committee	Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Moorlands Property Ltd	Directorships	16 August 2022		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		Companty Director - Springfield Property Lettings Ltd	Directorships	16 August 2022		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	*Directorships*	*12 March 2020*		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	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	21 January 2026	
		Member of Yoga Professional Alliance	Non-Financial Personal	July 2025		
		Part-time Yoga Teacher at Burnham Swim and Sports Academy Leisure Centre	Financial Interest	July 2025		

UNCONFIRMED MINUTES OF THE AUDIT, RISK AND ASSURANCE COMMITTEE OPEN MEETING HELD AT CARDIFF MRD AND REMOTELY VIA MICROSOFT TEAMS ON 2 DECEMBER 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
Wendy Herbert	Deputy Director of Putting Things Right *(Deputising for Liam Williams)*
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
Hugh Parry	Trade Union Representative *(Deputising for Christian Fox)*
Ed Roberts	Acting Executive Director of Finance & Resources *(Deputising for Chris Turley)*
Damon Turner	Trade Union Representative
Carl Window	Local Counter Fraud Manager
Emma Wood	Chief Executive

IN ATTENDANCE:

Sarah Harland	Corporate Governance Officer
James Houston	Assistant Director of Planning &Transformation *(Item 5.2.3)*
Jonny Sammut	Director of Digital
Andy Swinburn	Director of Paramedicine *(Item 05.2.2)*

APOLOGIES:

Judith Bryce	Assistant Director of Operations, National Operations & Support
Christian Fox	Trade Union Representative
Chris Turley	Executive Director of Finance & Corporate Services
Liam Williams	Executive Director of Quality & Nursing

1. WELCOME, APOLOGIES AND QUORUM

1.1 The Chair welcomed members and apologies were noted. It was confirmed the meeting met quorum.

2. DECLARATIONS OF INTEREST

2.1 No interests were declared.

3. MINUTES OF THE LAST MEETING 2 SEPTEMBER 2025

3.1 The minutes from the open meeting of the Audit Risk and Assurance Committee (ARAC) held on 2 September 2025 were considered. Ed Roberts asked that apologies from Chris Turley be added. Subject to this addition, the minutes were approved.

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 2 September 2025 was noted.

5. INTERNAL AUDIT

5.1 INTERNAL AUDIT PROGRESS REPORT

5.1.1 Osian Lloyd reported that delivery of the 2025/26 Internal Audit Plan is on track, with five final reports issued, eight in progress, two at planning stage and five scheduled for Q4. A change in the plan replaced the remote support audit with clinical prioritisation and assessment software group audits, with further discussions planned for next year. A new follow-up approach now reviews at least 50% of high-priority and 10% of medium-priority recommendations. Of 38 expected closures, 26 were confirmed closed, and 5 of 6 sampled closures verified, with 1 reopened but now believed closed. KPIs remain largely green, with 1 amber, and overall progress is positive.

5.1.2 The Chair sought assurance of completion by June, which Osian confirmed, and requested clarification on the reopened item. Trish Mills explained it was reopened due to insufficient evidence but is now believed closed and will be revisited at the next meeting. Trish also supported the new ongoing follow-up approach, noting it strengthens assurance and aligns with structured assessment practices.

The Committee took assurance from the Internal Audit Progress Report.

5.2 **INTERNAL AUDIT REPORTS**

5.2.1 Mandatory In-Service Training (MIST) Q2 – Reasonable Assurance

5.2.1.1 The Mandatory In-Service Training (MIST) audit was reviewed, showing reasonable assurance with four medium priority findings. The audit focused on operational, patient facing roles and highlighted strong compliance rates exceeding Welsh Government targets, but persistent non-compliance in some areas and gaps in role profile alignment and guidance dissemination.

5.2.1.2 Carl Kneeshaw welcomed the audit, confirmed actions are underway, and explained that resource constraints and training cycles justify longer implementation timelines, though statutory obligations are met. Jonny Sammut noted digital resource challenges but outlined ongoing recruitment and automation efforts. Committee members emphasised the importance of nuanced training needs analysis, effective guidance communication beyond Siren, quality assurance of on-the-job learning and proportionality in audit actions.

5.2.2 Clinical Equipment (Q2) - Reasonable Assurance

5.2.2.1 Osian Lloyd reported that the Clinical Equipment Internal Audit found significant improvement since the 2019 review, awarding reasonable assurance, but identifying one high and three medium priority findings, mainly around policy clarity, inventory management and maintenance records. The lack of a centralised inventory and inconsistent maintenance documentation, especially for defibrillators, were highlighted as ongoing issues.

5.2.1.2 Andy Swinburn acknowledged progress and immediate action on defibrillator tracking, while Jonny Sammut described a pilot for Radio Frequency Identification (RFID) tagging to address inventory gaps, noting feasibility and cost considerations.

5.2.2.3 Committee members welcomed improvements and supported the audit's direction, stressing the importance of robust equipment tracking to reduce theft and ensure patient safety.

5.2.3 Integrated Medium-Term Plan (IMPT) Development Process - Substantial Assurance

5.2.3.1 Osian Lloyd presented the Internal Audit of the Integrated Medium-Term Plan (IMTP), reporting substantial assurance and highlighting a structured, well-documented approach to IMTP development, strong stakeholder engagement and alignment with national priorities. The audit identified only minor areas for process refinement, resource prioritisation and governance, with all actions scheduled for completion before the next planning cycle.

5.2.3.2 James Houston welcomed the positive findings, noting that the audit recommendations aligned with the team's own internal review and actions were already being implemented to strengthen the planning process for the upcoming year.

5.2.3.3 Committee members expressed concern about the lack of a formal forum for joint strategic planning with health boards following the end of the Integrated Commissioning Action Plan (ICAP), emphasising the need for more collaborative and forward looking engagement. While efforts are being made to gain early insight into health board plans and participate in national programs, a comprehensive solution for joint planning is not expected in the next financial year, Emma Wood voiced her disappointment at the absence of formal opportunities for strategic engagement at present.

The Committee took assurance from the Internal Audit Reports:
1. **Mandatory In-Service Training (MIST);**
2. **Clinical Equipment; and**
3. **Integrated Medium Term Plan (IMPT) Development Process.**

6. AUDIT WALES

6.1 **AUDIT WALES UPDATE REPORT**

6.1.1 Fflur Jones presented the Audit Wales Update Report, noting that financial audit activity was quiet, with ongoing planning for the Charity Review and some delays in performance audit work, specifically the national Urgent and Emergency Care Report and the Digital Review, both now expected for the March committee. Fflur confirmed that the Estates Review will begin in the new year and the Non-Emergency Patient Transport Service (NEPTS) review is progressing well.

6.1.2 Committee members sought assurance on the completion dates for delayed reports, which Fflur provided, and discussed the upcoming independent examination of the Charity accounts, with Ed Roberts confirming preparations are on track. Rhiannon Beaumont Wood highlighted the importance of the Estates Review covering sustainability and workforce access, which Fflur confirmed, and Emma Wood raised the need to include utilisation, also acknowledged by Fflur. Jonny Sammut flagged governance gaps and risks in national Digital Programme delivery, suggesting actions for stakeholder engagement and clarity on the new Chief Digital Officer (CDO) role.

6.2 **STRUCTURED ASSESSMENT 2025 AND RESPONSE FORM**

6.2.1 Fflur presented the Structured Assessment, highlighting the Trust's strong governance, effective meetings and commitment to improvement. Meetings focus on key risks but reporting late papers as breaches would strengthen arrangements. The Trust's Board Assurance Framework (BAF) is improving with

a dedicated Risk Manager in place, though visibility of risk score changes need enhancement. Strategic planning and financial management are robust, with IMTP and wellbeing objectives in place, and a long-term strategy refresh is planned. The Trust met its financial duties, reduced reliance on non-recurrent savings, and improved reporting, but plans must remain realistic given wider financial pressures. All previous recommendations, as well as those relating to the 2024 cost savings review have been completed, which is uncommon across health bodies, and shows strong commitment to improvement. Four new recommendations have been made, with clear and realistic responses provided in the Appendix.

6.2.2 The committee responded positively to the 2025 Structured Assessment. The Chair praised Trish and the team for their commitment to improvement and strong delivery of recommendations. Trish highlighted the multidisciplinary effort, outlined actions for the four new recommendations, and stressed improving BAF effectiveness and reporting on slippage.

6.2.3 Wendy Herbert confirmed progress on the Quality Strategy Plan, monitored through QuEST, using existing skills and resources. Ceri Jackson welcomed the assurance but noted the challenge of balancing efficiency and effectiveness in BAF processes and the need for adequate resources. Julie Boalch reported efforts to digitise the BAF to reduce manual effort and strengthen assurance. Rhiannon Beaumont-Wood echoed positive feedback, recognised governance progress, but raised concerns about resourcing for the Quality Plan while supporting embedding Risk Appetite Statements.

6.3 **NATIONAL FRAUD INITIATIVE 2024/25: UPDATE FOR WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST**

6.3.1 Fflur Jones introduced the National Fraud Initiative (NFI) update, explaining it is a UK-wide Counter Fraud exercise conducted every two years to help prevent and detect fraud by matching data across public sector organisations. Fflur noted the 2024/25 NFI exercise is underway, summarised the briefing note's coverage of national and local data for the Trust, and advised that Audit Wales will soon assess NFI governance and follow-up arrangements in collaboration with Carl Window, with insights contributing to the next national report scheduled for autumn 2026.

6.3.2 The Chair stressed the importance of fraud awareness, especially around creditors, and vigilance against cyber and financial crime. Carl Window assured the committee that while resources for NFI match reviews are limited, engagement continues, matches are risk prioritised, and most issues are errors or duplications handled by finance teams. Carl noted ongoing discussions with Audit Wales to improve NFI efficiency. Ed Roberts confirmed strong controls within NWSSP-managed finance systems, including strict procedures

for bank detail changes and multiple checks to prevent fraud. Both Carl and Ed emphasised that fraud risk is minimal due to these measures.

The Committee took assurance from the Audit Wales Reports, as listed:
1. **Audit Wales Update Report;**
2. **Structured Assessment 2025 (and Response Form), noting these will be presented to the Trust Board in January; and**
3. **National Fraud Initiative 2024/25: Update for Welsh Ambulance Services University NHS Trust.**

7. BOARD AND COMMITTEE QUALITY & GOVERNANCE REVIEWS 2025/26

7.1 Trish Mills outlined proposed changes to streamline the committee structure, including reducing board committees from seven to six, disbanding the Academic Partnership Committee (APC) and redistributing its responsibilities. Trish emphasised aligning committee work with strategic objectives and noted that the Good Governance Institute (GGI) will conduct an external review of board effectiveness, which will encompass the spread of committees.

7.2 Committee members supported the pragmatic approach, highlighting the need to balance effective scrutiny with Non-Executive Directors' (NEDs) time commitments, and agreed on four NEDs per main committee with a quorum of three. It was recommended that the GGI review meeting efficiency and discussed combining Board Development activities. The committee agreed to recommend these changes to the Trust Board, with implementation subject to further modelling of NED commitments and the GGI review and noted that changes could be made mid-year if appropriate.

The Committee:
1. **Noted the issues considered with respect to the wider board committee framework changes and endorsed 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. **Endorsed 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. **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.**
4. **Recommend to the board that their quality and governance review includes a repeat of the survey conducted in 2024/25.**

8. RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

8.1 Julie Boalch reported that seven new Risk Appetite Statements were approved, reflecting the Trust's greater openness to risk and innovation, with next steps focused on embedding these statements, aligning them with strategic objectives and digitising risk management.

8.2 Committee members praised the progress, highlighted the value of clear risk appetite, and supported ongoing efforts to improve digital solutions and system-wide collaboration.

The Committee:

1. **Considered 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;**
2. **Took assurance from the 2025/26 programme of work;**
3. **Took assurance on the review and attention to the principal risks and their review at the Executive Leadership Team and at relevant Committees;**
4. **Noted that the reframed Reputational Risks 201a and 201b are overseen by the Board rather than the People & Culture Committee in future; and**
5. **Noted the ratings, mitigating actions and scoring trends for each principal risk.**

9. AUDIT TRACKER 2025/26 Q2 REPORTING (JULY- SEPTEMBER 2025)

9.1 Trish Mills reported a strong 71% closure rate for internal audit recommendations in Q2, with only 5.5% open or overdue, outperforming health board averages and reflecting realistic planning, though many actions are due in upcoming quarters.

9.2 Jonny Sammut reported on digital initiatives, noting progress in records management (with digitisation plans pending funding), clinician-level access for Electronic Patient Care Records (on track for April), and contract management improvements despite resource constraints. Wendy Herbert highlighted legal limits on expanding patient surveys, good uptake in ambulance care, and ongoing team capacity challenges, with the March 2026 target for survey expansion uncertain due to delays with the Information Commissioner. Carl Kneeshaw reported that the new NHS Wales Occupational Health System lacks full KPI data, with a supplier fix expected in six months and September next year as the revised target. Procurement alternatives are limited due to the All-Wales contract.

9.3 Committee members were satisfied with closure rates and transparency but emphasised the need to monitor upcoming deadlines, resource constraints, and external dependencies such as the Information Commissioner and system suppliers

The Committee:

1. **Took assurance from the progress made in closing audit actions during 2025/26 Quarter 2;**
2. **Noted the audit actions for which final revised dates have been applied in quarter and the updates provided from the Directors responsible for these audits;**
3. **Took assurance that the management actions for the audits within the purview of this Committee are being effectively and appropriately managed; and**

10. POLICY REPORT – PROGRESS AGAINST 2025/26 POLICY WORK PROGRAMME

10.1 Trish Mills reported that, of the 62 policies in the 2025/26 programme, 47 remain with 29 still outstanding, just under 60%. Many policies were front-loaded to the first half of the year but have slipped due to operational pressures, capacity challenges, and recruitment gaps, making it unlikely all will be completed this year. Escalation to the Executive Leadership Team and monthly monitoring are in place, with a process review planned for Q4 to help streamline and prioritise future the end to end policy process.

10.2 Committee members recognised the challenges in completing all policies and stressed prioritising those with significant impact over minor updates. Ceri Jackson and Emma Wood supported a pragmatic approach, suggesting that less critical policies could be extended while focusing on those with real implications. Damon turner noted most updates are minor, such as job title changes, and that policy quality has improved.

The Committee:

1. **Took assurance on the governance and process surrounding the current policy programme; and**
2. **Noted the remaining 2025/26 Policy Work Programme and trajectories.**

11. LOSSES AND SPECIAL PAYMENTS
(Payments for the period 1 April – 31 October 2025)

11.1 Ed Roberts reported a £1.9 million refund during the period, mainly from £2.8 million in Welsh Risk Pool claims, with a £19,000 refund for vehicle damage miscoding. Committee members noted the unpredictability of these payments and discussed Audit Wales's suggestion for trend analysis. Ed explained that WAST's losses are more random than health boards', but he and Wendy Herbert agreed to explore adding more context and learning to future reports, such as deep dives into key themes and sharing lessons from successful claims.

The Committee noted the Losses and Special Payments Report.

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

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

The Committee noted the Cycle of Business Monitoring Report and Priorities Update.

13. REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

13.1 Trish Mills noted challenges with hybrid meetings, especially technical issues and chairing remotely, and suggested improvements. Ceri Jackson and Rhiannon Beaumont-Wood felt the format worked well, with good scrutiny and balanced discussion. The Chair expressed his preference to in-person meetings but found the hybrid approach effective, highlighting strong contributions.

14. ANY OTHER BUSINESS

14.1 None declared.

15. DATE OF THE NEXT MEETING

15.1 The next meeting is scheduled for the 2 March 2026.

The meeting closed at 12:50

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 12 December 2025 from Fflur Jones** Following ASM, Fflur confirmed this report will be presented to the March 2026 meeting, agenda item 6.1. **Update 2 December 2025 from Fflur Jones** Fflur confirmed that she will provide an update at the March 2026 meeting, the report is currently in draft format. **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.	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 18 February 2026** The focus has been on the PTR Recovery Plan with little movement in near miss reporting, however it is anticipated that once recovered this position will improve. A verbal update will be provided at the meeting 2 March 2026. **Update 12 December 2025** Following the ASM, it was confirmed this will be updated through the Action Log following the meeting of QuEST to provide an update on the position. **Update 2 December 2025 from Trish Mills** Trish Mills reported that she will bring an update to the March 2026 meeting, there are no expected changes until then. **Update 4 November 2025** The QuEST Committee received a AAA from ARAC regarding Near Miss and Low Harm Intelligence Reporting.	Open

AUDIT, RISK AND ASSURANCE COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report. The papers for these meetings can be found by following this link to the Committee page on the Trust website.

Trust Board Meeting Date	29 January 2026
Committee Meeting Date	2 December 2025
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS
ALERT (Alert the Board to areas of attention)
1. The **2025 (core) Structured Assessment** was presented at this meeting and will also be presented to the board at its January meeting. The committee expressed strong assurance and satisfaction with the structured assessment, noting the positive findings and minimal recommendations. Members expressed confidence in the ongoing improvement trajectory.
ADVISE (Detail any areas of on-going monitoring, approvals, or new developments to be communicated)
2. A **pre-meeting** was held with Audit Wales, Internal Audit and the committee Chair ahead of the meeting. 3. Members **reflected** that, despite technical issues and more members joining online than in person, it was a good meeting. The papers, presentations and scrutiny were excellent.
ASSURE (Detail here any areas of assurance the Committee has received)
4. Members supported the direction of travel presented in the **Quality Governance Review for 2025/26** endorsing all seven recommendations described in the preferred option one. They noted the further recommendation to defer material changes pending the externally facilitated board effectiveness review. A separate paper will be presented to the Board on this matter at the January meeting. The committee also endorsed the terms of reference for the People and Culture, the Finance and Performance, and the Quality Patient Experience and Safety Committees. These will be attached to the stand-alone paper for board approval in January.

5. **Audit Wales** updated the committee on progress, including:

    - 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.

    - Part three of the Review of Unscheduled Care (national arrangements and leadership structures) has experienced a delay and is being drafted. Members were assured this will be available at the March 2026 meeting.

    - The non-core Structed Assessment - Deeper Dive Review of Digital Transformation - is also at the drafting stage, with its presentation due at that March 2026 meeting.

    - The National Fraud Initiative (NFI) 2024/25 is underway. This biennial UK-wide counter-fraud exercise helps prevent and detect fraud by electronically sharing and matching data sets. Members were assured that WAST actively engages with the NFI, reviewing matches on a risk basis despite limited resources and no fraud cases found in recent years. Further assurances on credit and cyber fraud related matches were received.

6. **Internal Audit** reported steady progress against the 2025/26 plan with most KPIs showing as green; including report turnaround by management. Whilst a couple of reports have slipped there is confidence that the audit plan will be completed by June. The follow-up review of internal audit recommendations that is usually held in Q4 is now taking place throughout the year, and good progress was noted with appropriate closure of recommendations.

7. 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.

    - **Mandatory In-Service Training (MIST) – Reasonable Assurance**. The purpose of this review was to evaluate the impact and effectiveness of the new MIST days. The focus was on how well these arrangements support compliance with statutory and mandatory training requirements.

      The committee welcomed the audit and accepted the findings, with management actions underway and timelines considered realistic given current resource constraints. The committee was broadly assured but noted concerns about the length of time required to close some actions, particularly those dependent on digital resources and the training needs analysis. It was confirmed that statutory compliance targets are being met, and the main risk relates to individuals with significant non-compliance, not the organisation overall. The committee highlighted the need for improved communication of guidance to staff and for robust assurance on the quality of on-the-job learning. Digital resource constraints and recruitment challenges were acknowledged, with ongoing efforts to mitigate these through automation and transparency.

      The People and Culture Committee will review this alongside the usual mandatory training compliance KPIs at its January meeting.

- **Clinical Equipment – Reasonable Assurance**. The purpose of this review was to evaluate the effectiveness of the arrangements put in place to record, monitor and replace clinical equipment within the Trust. For this review, the focus was on portable clinical equipment used in patient care and transport. Members heard that significant improvements have been noted in relation to the health and safety concerns that were raised in a similar 2019 limited assurance audit, as well as improvements regarding acceptance testing and the maintenance records held.

  The committee was assured that actions to address overdue WAST defibrillator servicing are underway and that overdue devices are not concentrated in any one area. The feasibility study for RFID tagging is in progress and will support improved asset tracking.

  The Quality, Patient Experience and Safety Committee will review this at its January meeting.

- **Integrated Medium Term Plan (IMTP) Development Process – Substantial Assurance**. This was a review of the process undertaken for the development of the IMTP, including the mechanisms to identify priorities, engagement with stakeholders and alignment to national criteria.

  Members highlighted that the lack of a formal forum for joint strategic planning with Health Boards and partners limits system-wide strategic vision. While more engagement is planned, there is no immediate solution for the next financial year. Early engagement and cross-checking of priorities are being pursued. The committee agreed to continue advocating for better partnership working, with future national programmes potentially offering improved collaboration. The Finance and Performance Committee reviewed this audit at its November meeting.

8. There has been slippage in the 2025/26 policy work programme, with several policies deferred and 29 still outstanding for quarters 3 and 4, making year-end completion unlikely. With just under 54% of policies within review date, a further update is needed in March. Members welcomed the planned policy transformation programme for 2026/27, which aims to streamline processes.

9. The Losses and Special Payments were reviewed for the period from 01 April – 31 October 2025 and noted as being -£1.918 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.

10. The committee reviewed the Q2 2025/26 Audit Tracker and were assured that a positive audit culture is developing, with more audits closed on their original date, reflecting more realistic timelines. Directors or deputies confirmed that the seven audit actions on their final deadlines are achievable and that associated risks are not increasing.

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

12. In private session the Committee received the **local counter fraud** update and the **tender update** and single tender awards. Of note for the board:

    - There were 10 investigations closed in this period (11 last quarter), with nine new referrals having been received (seven last quarter).
    - A recent Counter Fraud Awareness Survey found that while over 95 percent of staff are aware of Local Counter Fraud Specialists and know where to find policies, only 62 percent are confident about reporting suspected fraud, with some uncertainty about reporting channels. Fewer than half received training or communications in the past year, though those who did reported increased

awareness. Regular updates and clearer communications, featuring WAST specific examples, especially via Siren and online platforms, will be introduced to improve engagement.

- Members were provided with an overview of the new corporate offence of the failure to prevent fraud under the Economic Crime and Corporate Transparency Act 2023. The Act creates an offence where the Trust may be criminally liable where an employee or agent commits fraud intending to benefit the Trust when there are no reasonable fraud prevention procedures in place. Members were assured that measures were in place in line with the Counter Fraud Standards, although options to enhance diligence will still be considered
- Ten new tenders were issues during the reporting period 1 August to 31 October 2025 and 13 awarded. There was one request to waive Standing Financial Instructions related to continuing with an existing supplier for business continuity purposes.

RISK MANAGEMENT

13. Members were assured in respect of the Trust's principal risks with no material changes this period. In private session, Members received assurance on the details of Risk 620 and Risk 260 noting that there were no material changes during this period.
14. Members welcomed the seven risk appetite statements approved by the board, noting the implementation and embedding principles will be included in next year's work program along with options for a digital risk platform and a specific focus on the impact of actions on risk scores.

COMMITTEE AGENDA FOR MEETING IN DECEMBER 2025		
Internal Audit: - Progress report - MIST audit report - Clinical equipment audit report - IMTP development process audit report	Audit Wales: - Update report - Structured Assessment 2025 - National Fraud Initiative 2024/25	Board and committee quality governance reviews 2025/26
Risk Management and BAF	Audit tracker Q2 2025/26	Bi-annual policy report
Losses and special payments	Cycle of business monitoring report and priorities update	

COMMITTEE ATTENDANCE

Name	1 May 2025[1]	24 Jun 2025[2]	2 Sep 2025	2 Dec 2025[3]	2 Mar 2026	
Peter Curran						
Ceri Jackson						
Rhiannon Beaumont-Wood						
Chris Turley			Ed Roberts	Ed Roberts		
Audit Wales	Fflur Jones	Fflur Jones	Fflur Jones	Fflur Jones		
Julie Boalch						
Judith Bryce	Jon Sweet		Pete Brown			
Christian Fox				Hugh Parry		
Carl Kneeshaw						
Osian Lloyd						
Trish Mills						
Liam Williams		Wendy Herbert		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

[3] Emma Wood, CEO joined this meeting

Internal Audit Plan 2026/27

Welsh Ambulance Services University NHS Trust

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1. Introduction

This document sets out the Internal Audit Plan for 2026/27 (the ‘Plan’) detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation’s governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit, Risk and Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the key findings and agreed actions from internal audit reviews may be used by Trust management to improve governance, risk management, and control within their operational areas.

The Global Internal Audit Standards (the ‘Standards’) became effective in January 2025 and apply to UK public sector audits from 1 April 2025 to align with the financial year. These Standards replaced the previous Public Sector Internal Audit Standards. They are supported by a UK public sector application note (the ‘Application Note’), which provides sector-specific interpretations and additional requirements. The Standards require that a risk-based internal audit plan is developed to support the achievement of the organisation’s objectives.

Accordingly, this document sets out the risk-based approach and the Plan for 2026/27. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC). These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging

issues throughout the year. Any necessary updates will be reported to the Audit, Risk and Assurance Committee in line with the Internal Audit Mandate and Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Director of Corporate Governance (Board Secretary) and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our Plan is made up of several key components:

1) Consideration of key governance and risk areas: We have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register, together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up - This work involves reviewing a sample of high and medium priority findings that the organisation has reported as closed on the recommendation tracker, to confirm that actions have been implemented appropriately and to assess the impact these actions have on governance and control arrangements.

4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that may impact on the Trust, namely NWSSP, DHCW, and the JCC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the final business case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all the requirements of the

Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Trust's systems of assurance

The risk based internal audit planning approach integrates with the Trust's systems of assurance; therefore, we have considered the following:

- A review of the Board's vision, values and forward priorities as outlined in the Integrated Medium-Term Plan (IMTP);
- An assessment of the Trust's governance and assurance arrangements and the contents of the corporate risk register;
- Risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee and the Quality, Patient Experience and Safety Committee);
- Key strategic risks identified within the corporate risk register and assurance processes;
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes;
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- New developments and service changes;
- Legislative requirements to which the organisation is required to comply;
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC;
- Work undertaken by other supporting functions of the Audit, Risk and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate;
- Work undertaken by other review bodies, including Audit Wales and Healthcare Inspectorate Wales; and
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the Trust Executive and Non-Executive Directors to discuss current areas of risk and related assurance needs. The draft Plan has been provided to the Trust's Executive Management Team and the Non-Executive Directors to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and corporate risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also considers corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2026/27

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan refers to key strategic risks identified within the corporate risk register and related systems of assurance, together with the proposed audit response within the outline scope.

When developing the audit scope, in discussion with the responsible executive director(s) and operational management, the scope, objectives and audit resource requirements, and timing will be refined in each area.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit, Risk and Assurance Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit, Risk and Assurance Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our Digital and IT team, in terms of information governance, IT security and digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit, Risk and Assurance Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan has been put together based on the planning process described in this document. The Plan includes sufficient audit work to be able to give an annual Head of Internal Audit opinion in line with the requirements of Standard 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit, Risk and Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Trust, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

Under the approach we have adopted for a number of years, the top slice provided to us to undertake the internal audit programme is supplemented by an additional charge for work undertaken over and above the 'top slice' arrangements. To this end the Trust has agreed to pay an additional £50,099 to cover this additional audit work.

Also, under the approach we have adopted since the formation of NWSSP we charge for the specialist Capital and Estates work delivered as a part of the agreed plan. For 2026/27 this additional charge is £13,405. The audit of major programmes/projects will be facilitated through the Integrated Assurance and Approval Plans agreed at the respective business cases approved and funded by Welsh Government. There are currently no Trust projects proposed for review facilitated through the Integrated Assurance and Approval Plan process during 2026/27. Therefore, the Trust will be charged an additional amount of £63,504 which is over and above the 'top slice' recharge agreed as part of NWSSP's overall funding for 2026/27. Recharges may be adjusted to reflect annual NHS inflationary uplifts.

6. Action required

The Audit, Risk and Assurance Committee is invited to consider the Internal Audit Plan for 2026/27 and:

- approve the Internal Audit Plan for 2026/27;
- approve the Internal Audit Mandate and Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Osian Lloyd
Head of Internal Audit
Audit and Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2026/27

Planned output, Outline scope, Review reference, Review type	Corporate Risk Register Reference	Lead Executive Director	Planned start
1 Risk Management & Board Assurance (Assurance) To assess the effectiveness of strategic risk management arrangements, including the development, operation and use of the Board Assurance Framework (BAF) in supporting Board level oversight of the organisation's strategic objectives. Or To assess the maturity, consistency and effectiveness of directorate level risk management arrangements in preparation for, or early transition to, the new enterprise risk management system and model.		Director of Corporate Governance / Board Secretary	Q4
2 Follow Up (Assurance) To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.		Director of Corporate Governance / Executive Team	Q1 - Q4
3 Savings Planning and Monitoring Arrangements (Assurance) Review the processes and governance arrangements for identifying, approving, and delivering savings plans. Assess how savings initiatives are monitored, reported, and embedded within operational and financial planning.	139	Executive Director of Finance and Corporate Resources	Q3
4 Integrated Medium-Term Plan (IMTP) Delivery (Assurance) To assess the effectiveness of the new IMTP delivery and assurance framework in supporting robust oversight of plan implementation, and in ensuring alignment with financial, workforce and operational priorities.	100	Executive Director of Strategy, Planning and Performance	Q3/4
5 Commercial Development & Income Generation (Advisory)	139	Executive Director of Strategy,	Q2/3

Planned output, Outline scope, Review reference, Review type	Corporate Risk Register Reference	Lead Executive Director	Planned start
To review the emerging governance, planning and risk management arrangements supporting the organisation's commercial development and income generation strategy, ensuring alignment with wider financial sustainability objectives as the strategy evolves.		Planning and Performance	
6 Family Complaints – Putting Things Right & Legal Services Recovery Plan (Assurance) To provide assurance on the effectiveness and sustainability of the PTR & Legal Services Recovery Plan as it relates to family complaints, including compliance with the new complaints' regulations coming into force in April. The review will assess timeliness, quality, governance, and the capacity of the service to meet statutory expectations.	223, 224	Executive Director of Quality and Nursing	Q3
7 Medical Examiner System & Mortality Reviews (Assurance) To assess whether governance, timeliness, quality and learning processes within the Medical Examiner system and mortality review arrangements are effective and sustainable, and whether the Trust is meeting national requirements.	223, 224	Executive Director of Quality and Nursing	Q1/2
8 Clinical Navigator Role – Effectiveness and Integration (Assurance) To assess the effectiveness, impact, and integration of the Clinical Navigator role within clinical and operational decision-making processes.	223	Executive Director of Paramedicine	Q2/3
9 Operations Directorate Structure and Governance Arrangements (Assurance) To assess whether Directorate structures, roles, and governance arrangements are clearly defined, consistently applied, and operating effectively, including lines of accountability, decision-making, and escalation.	223	Executive Director of Operations	Q1

Planned output, Outline scope, Review reference, Review type	Corporate Risk Register Reference	Lead Executive Director	Planned start
10 Shift Overruns (Assurance) To review the operational processes and actions taken to reduce shift overruns, including the effectiveness of action plans and the work of the associated working group. The audit could also consider the cultural and wellbeing impacts of overruns, alongside the accuracy of reporting and payment arrangements.	139, 558	Executive Director of Operations	Q2
11 Time off in lieu (TOIL) (Assurance) To review the application, scrutiny, and monitoring of the TOIL arrangement, including how the Task & Finish Group is overseeing and informing its development. The audit will assess whether TOIL is being implemented consistently, managed in line with agreed principles, and supported by appropriate oversight and reporting.	139, 558	Executive Director of Operations	Q3
12 Medical Gases (Assurance) To assess the adequacy and effectiveness of the organisation's processes for ordering, managing, using, and disposing of medical gases, and to evaluate whether contractual, financial, and operational risks are being appropriately managed.		Executive Director of Paramedicine	Q1/2
13 Cyber Security (Assurance) To review the adequacy and effectiveness of the processes in place for patching, vulnerability management, and third party cyber assurance, and to provide assurance that cyber security risks are appropriately identified, clearly understood, and managed in line with the organisation's risk appetite.	260	Director of Digital	Q1/2
14 Shadow IT (Assurance) To provide assurance over the governance processes for the management and use of IT system(s) operating outside the Digital function, and to	260	Director of Digital	Q2/3

Planned output, Outline scope, Review reference, Review type	Corporate Risk Register Reference	Lead Executive Director	Planned start
confirm that mechanisms exist to identify and assess the presence and impact of unauthorised IT systems and applications within the Trust. The review will include consideration of security vulnerabilities, compliance issues, and potential risks to data integrity.			
15 Service Management (Assurance) To provide assurance that digital services provided meet the needs of the organisation and are aligned with the ITIL framework. The review will focus on key areas including service desk provision, incident management, problem management, monitoring, and continual service improvement.	260	Director of Digital	Q3/4
16 Secondary Employment: Disclosure and Control Arrangements (Assurance) To review the arrangements for disclosing and monitoring secondary employment across the organisation. The audit will assess the adequacy of controls, including the completeness and accuracy of records, and the effectiveness of the associated governance and assurance processes.		Director of People / Director of Corporate Governance / Board Secretary	Q1/2
17 Anti-Sexual Harassment Policy & Implementation Plan (Assurance) To assess the effectiveness of the Trust's implementation of the Policy and associated Implementation Plan. The review will consider staff awareness, education, understanding, and manager capability; evaluate how delivery and impact are measured; and examine the governance and assurance arrangements for identifying, escalating, and monitoring concerns, including links to safeguarding processes where staff behaviour is implicated.	160	Director of Culture Change / Executive Director of Quality and Nursing	Q4
18 Stress Management (Assurance) To assess the Trust's approach to managing work related stress and associated wellbeing risks, drawing on benchmarking against the HSE	160, 558	Executive Director of Quality & Nursing / Director of People	Q3/4

Planned output, Outline scope, Review reference, Review type	Corporate Risk Register Reference	Lead Executive Director	Planned start
improvement notice issued to East of England Ambulance Service and ensuring appropriate governance, mitigations, and oversight are in place.			
19 Estates Assurance: Control of Contractors (Assurance) To assess whether contractors are managed safely and effectively while on Trust premises, in line with organisational policies and required standards. The review will confirm that all legal and regulatory obligations are met, including Right to Work in the UK checks. *Scope to be reviewed as part of planning.*		Executive Director of Finance and Corporate Resources	TBC

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2026/27
Audit plan 2026/27 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2026/27 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit, Risk and Assurance Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	85%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 working days]	✓	95%

Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Mandate and Charter:

- Board means the Board of Welsh Ambulance Services University NHS Trust with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit, Risk and Assurance Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Welsh Ambulance Services University NHS Trust. The Chief Executive has made arrangements within this Mandate and Charter for an operational interface with internal audit activity through the Director of Corporate Governance (Board Secretary).

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of the Welsh Ambulance Services University NHS Trust. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit, Risk and Assurance Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence is described in the Global Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit, Risk and Assurance Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit, Risk and Assurance Committee on behalf of the Board. Such functional reporting includes the Audit, Risk and Assurance Committee:

- approving the internal audit mandate and charter.
- approving the risk based internal audit plan.
- approving the internal audit resource plan.
- receiving outcomes of all internal audit work together with the assurance rating. and

- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Mandate and Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Mandate and Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit, Risk and Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Global Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit, Risk and Assurance Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit, Risk and Assurance Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit, Risk and Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit, Risk and Assurance Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any

committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, and NHS Wales Joint Commissioning Committee.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit, Risk and Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit, Risk and Assurance Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit, Risk and Assurance Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several Key Performance Indicators, and we will agree with each Audit Committee

which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit, Risk and Assurance Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- ensuring effective co-ordination, as appropriate, with external auditors and other regulators; and
- reviewing the Annual Governance Statement prepared by senior management.

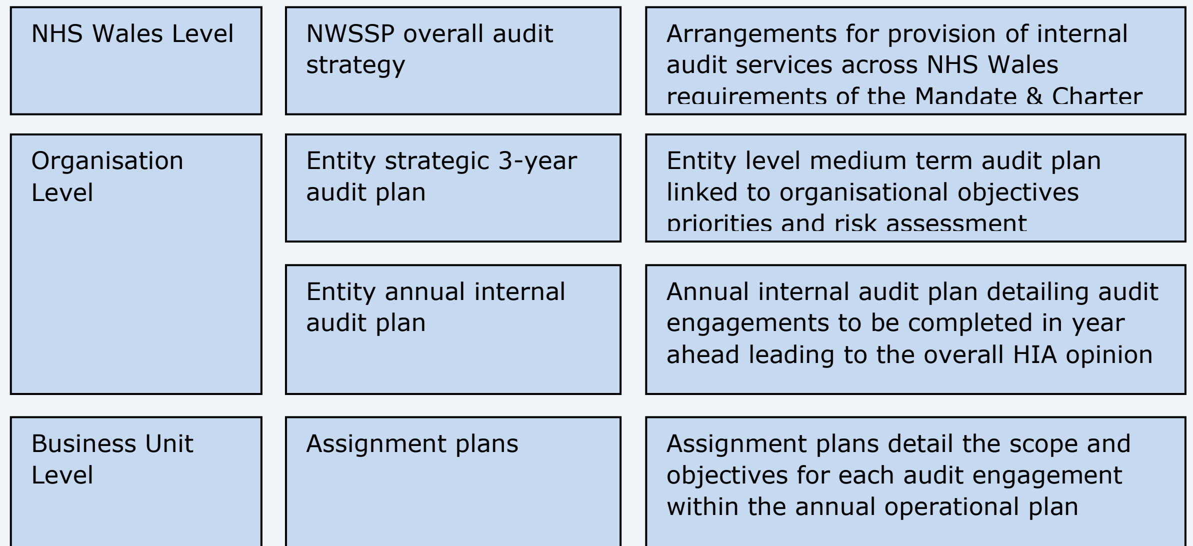
7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.

7.3 If the Head of Internal Audit or the Audit, Risk and Assurance Committee consider that the level of audit resources or the Mandate and Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Mandate and Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy



8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit, Risk and Assurance Committee of an overall opinion each year on the organisation’s risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation’s risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation’s objectives and risks;
- improvement of the organisation’s risk management, control and governance by providing management with

constructive recommendations arising from audit work;

- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit, Risk and Assurance Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

9.1 Internal Audit will report formally to the Audit, Risk and Assurance Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  - a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  - b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  - c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;

d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;

e) Compare work undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and

f) Provide a statement of conformity in terms of compliance with the Global Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit, Risk and Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit, Risk and Assurance Committee requirements; and
- The Audit, Risk and Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations.
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit, Risk and Assurance Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit, Risk and Assurance Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director

of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit, Risk and Assurance Committee where no management response is forthcoming.

- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - ➢ Specific
  - ➢ Measurable
  - ➢ Achievable
  - ➢ Relevant / Realistic
  - ➢ Timely.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit, Risk and Assurance Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access is granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Global Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Global Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit, Risk and Assurance Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit, Risk and Assurance Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Mandate and Charter

14.1 This Internal Audit Mandate and Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit, Risk and Assurance Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
February 2026

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 Mandate and Charter as approved by the Audit, Risk and Assurance Committee.

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

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 regarding the advice and information contained.

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

Global 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 Global Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023. Please note that new Global Internal Audit Standards apply from April 2025, and all future audit work will comply to these new Standards.

Internal Audit Progress Report

Audit, Risk and Assurance Committee

March 2026

Welsh Ambulance Services University NHS Trust

NWSSP Audit and Assurance Services

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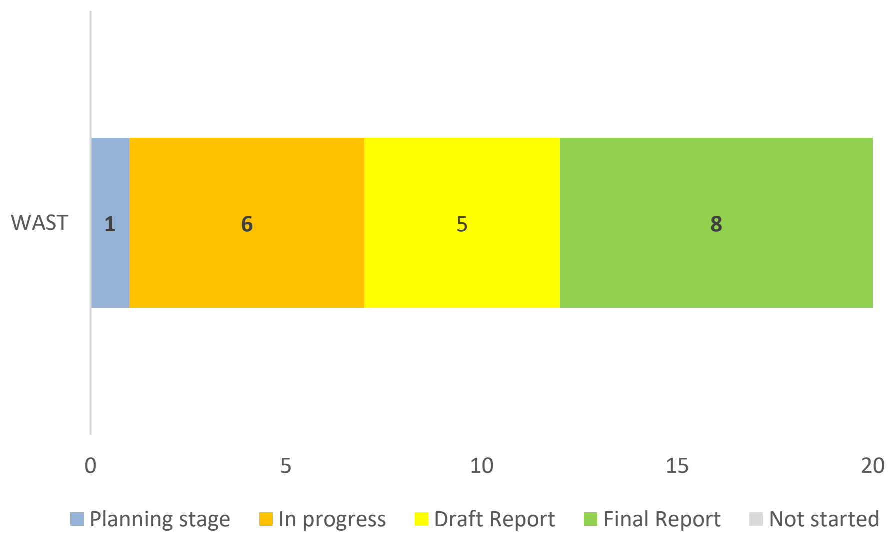
1. Introduction

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 the approved plan

No further changes are proposed to the 2025/26 Internal Audit Plan.

4. Planning for 2026/27

The draft Internal Audit Plan has been discussed with the Executive Team and circulated to Non-Executive Directors for comment. The final version is included within the Committee papers for consideration and approval.

The plan will remain flexible throughout 2026/27 to accommodate new and emerging risks, and we will re-visit it regularly to enable ongoing discussion of priorities.

5. 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.

The conclusions from our first review, covering recommendations with an expected implementation date on or before 31 March 2025, were reported to the December 2025 ARAC. Our second review has been considered in two tranches: (1) recommendations due for implementation on or before 31 May 2025; and (2) recommendations due for implementation on or before 30 September 2025, aligning with the Quarter 1 and Quarter 2 updates respectively provided by the Head of Compliance & Assurance.

Of the 97 high and medium priority recommendations issued in 2024/25:

- 31 March 2025: 38 recommendations were expected to be closed by this date, of which 26 (68.4%) were closed.
- 31 May 2025: 15 recommendations, including seven from our previous review, were expected to be closed by this date. Closure had been recorded on the tracker for four (26.6%) of these. Of the 11 remaining open items, all had revised target dates recorded on the tracker: six in Quarter 2 of 2025/26 and five in Quarter 3.
- 30 September 2025: 30 recommendations, including nine from our previous two reviews were expected to be closed by this date. Closure had been recorded on the tracker for 22 (73.3%) of these. Of the eight remaining open items, seven had revised target dates recorded on the tracker: two in Quarter 3 of 2025/26 and five by the end of the financial year. One item was still pending assignment of a target date.

Overall, 52 of the 67 recommendations expected to be closed by 30 September 2025 have been reported as closed, representing a closure rate of 77.6%. We recognise that eight of these recommendations had revised implementation dates assigned.

A sample of five recommendations (two high priority and three medium priority) from four reports was selected for validation for the period 1 April to 31 May 2025 (see Table 1 in appendix B), and a further three recommendations (two high priority and one medium priority) from three reports were selected for validation for the period 1 June to 30 September 2025 (see Table 2 in appendix B). Sufficient evidence has been provided to confirm closure for four of the recommendations. At the date of reporting, we have been unable to conclude on four recommendations (from the Emergency Nurse Communications System Implementation, Public Engagement & Community Involvement and Data Quality reports) as additional evidence has been requested.

Across the reported reviews, we have therefore confirmed the closure of 10 of the 14 recommendations sampled. Our next review will consider those recommendations with an expected implementation date of 31 December 2025, aligning with the Quarter 3 update provided by the Head of Compliance & Assurance. A further 20 recommendations (including seven from our reviews to date 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 April 2026 Audit, Risk & Assurance Committee.

6. 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.

7. Key Performance Indicators

Correct on 31 January 2026

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2025/26		March	By 30 June
Audits reported over planned		11	13
Work in progress		6	
Report turnaround: time from fieldwork completion to draft reporting [10 days]		8 out of 11	80%
Report turnaround: time taken for management response to draft report [15 days]		5 out of 7	80%
Report turnaround: time from management response to issue of final report [10 days]		6 out of 6	80%

Key:

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

8. Recommendation

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

Appendix A: Progress against 2025/26 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Risk Management and Assurance	In progress			April 2026
Welsh Language Standards	Draft report	Reasonable	The audit highlighting positive foundations for compliance with the Standards but identifying weaknesses in monitoring, oversight, governance attendance, complaints recording, and the need for clearer structured accountability.	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.		April / June 2026
Budget Setting	Final report	Reasonable	Strengthening contingency oversight, budget-holder financial skills, and formal accountability arrangements will reinforce the Trust's budget-setting process and support financial resilience in an increasingly challenging environment.	March 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	Final report	Reasonable	Strengthening benefits measurement, dependency mapping, and milestone visibility will enhance assurance over CMTP delivery, supporting clearer impact demonstration and more consistent programme oversight.	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	December 2025

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			organisational change and resource pressures.	
Cymru High Acuity Response Unit (CHARU)	Final report	Reasonable	Strengthening training oversight, establishing structured benefits evaluation, and ensuring frontline representation in governance will enhance assurance over CHARU's clinical impact and support more consistent, evidence-driven service development.	March 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	In progress			April / June 2026
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	In progress			April 2026
High Risk Record Policy	In progress			April / June 2026
Data management practices / Devolved data	Draft report	Reasonable	Strengthening organisation-wide data standards, central oversight, and consistent validation processes will improve the quality, consistency, and reliability of devolved reporting, supporting robust decision-making and safeguarding the Trust's data governance arrangements.	April 2026
Emerging technology adoption	In progress			April 2026
Business Continuity	Draft report	Reasonable	Strengthening ICT continuity planning, consolidating disaster recovery arrangements, and improving Trust-wide oversight and testing of business continuity processes will enhance digital	April 2026

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			resilience and assurance during system disruption.	
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	Draft report			April 2026
Ambulance Replacement Programme	Planning			April / June 2026
Fire Safety	Draft report			April 2026

[1] May be subject to change

Appendix B: Follow Up of Internal Audit Recommendations

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

Report Title	Recommendation reference & detail		Priority rating	Internal Audit Assessment
Limited Assurance Reports				
Vehicle Accident Management (February 2025)	3	Recording vehicle incidents onto Datix – discrepancy between Datix and Fleetwave.	**High**	Appropriately classified as closed.
	4	Unreported incidents and unknown damage – a high number of incidents without an attached Traffic Accident Report Form.	**High**	Appropriately classified as closed.
Reasonable Assurance Reports				
Emergency Nurse Communications System Implementation (May 2025)	8	Actions to address non-compliance rates – actions not captured formally with associated timescales and leads.	**Medium**	Additional information required.
Public Engagement and Community Involvement (November 2024)	3.3	Regular review of survey questions and responses – formal mechanism to confirm that services have reviewed feedback and provide an update on the action taken.	**Medium**	Additional information required.
Rollout of Penthrox (February 2025)	4	Reporting / benefits realisation – lack of reporting on the use of Penthrox and its effectiveness.	**Medium**	Appropriately classified as closed.

Table 2: Sample of closed recommendations as at 30 September 2025.

Report Title	Recommendation reference & detail		Priority rating	Internal Audit Assessment
Reasonable Assurance Reports				
Data Quality (October 2024)	3.1	Incomplete Information Asset Register.	**High**	Additional information required
Emergency Nurse Communications System Implementation (May 2025)	2	ECNS Audit Arrangements – capacity constraints within the Professional Practice Education (PPE) team.	**High**	Additional information required.
Capital Systems (June 2025)	1	Capital Procedures – project checklist.	**Medium**	Appropriately classified as closed.

Budget Setting

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust

Reasonable Assurance

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Review Reference	WAS-2526-04
Fieldwork	October - December 2025
Executive Sign Off	15 February 2026
Audit Committee	2 March 2026
Executive Lead	Chris Turley. Executive Director of Finance & Corporate Resources
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

Executive Summary

Purpose

To review how the Trust allocates resources to meet its agreed budget. As the review is being undertaken across five NHS Wales organisations, it will enable comparison of financial planning and budget setting arrangements and the identification of common themes and good practice. A summary report will be produced once all reviews ae completed.

Overview

Under the NHS Finances (Wales) Act 2014, local health boards and NHS trusts have a statutory duty to prepare a three-year Integrated Medium Term Plan (IMTP), which is updated annually, that sets out how they will comply with their financial break-even duties over a rolling three-year period.

The Well-being of Future Generations (Wales) Act 2015 set in law the need to consider the long-term strategic approach to deliver a better future, including within financial planning and budget setting. We note 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.

The Trust's Financial Plan (2025/26) was approved by the Board on 27 March 2025 prior to submitting for approval by Welsh Government in accordance with the timelines set. The Plan assumed a 1.77% uplift in funding from health boards, who provide the main funding to the Trust, and required significant savings of £8.5m to achieve a break-even position. At Month 7 (October 2025), the Trust is currently forecasting to breakeven by the 2025/26 financial year end and to achieve its £8.5m savings.

Our audit focused on the budget setting and financial planning arrangements for 2025/26. A separate detailed internal audit review of the development of the Integrated Medium-Term Plan (IMTP), which encompassed some financial aspects, concluded substantial assurance (issued: October 2025).

We have concluded reasonable assurance on this area. The Trust has consistently demonstrated sound financial planning arrangements, presenting a 2025/26 Financial Plan that met its statutory financial duty to achieve break-even, outlined key assumptions and risks, and ensured there was sufficient oversight of the Plan's development. The matters requiring management attention include:

- Improvements are required in the application of the contingency process to ensure there is consistent use and appropriate oversight of decisions.
- Enhancing the current financial training provision and monitoring of requirements to provide assurance that all budget holders are proficient.
- Ensuring that accountability letters are fully completed and signed to comply with the Standing Financial Instructions (SFIs).

Full details of matters arising are detailed within the Findings & Agreed Action Plan. For management information, we have highlighted that the Trust should consider the benefits of extending its use of zero-based budgeting to other areas where it is not currently applied. This represents an opportunity for enhancement 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 financial planning approach that aligns the key organisational priorities, available resources and Welsh Government's requirements.	-	**Substantial**
2	There is clear and robust challenge of the Financial Plan, its assumptions and associated risks by senior management, the Board and its committees, and Welsh Government.	1	**Reasonable**

3	Budget holders are effectively engaged at an early stage and supported throughout the budget setting process, and the Trust has sufficient internal resources, skills and systems to enable effective budget planning.	2	**Reasonable**
4	Roles, responsibilities and the arrangements for budget setting are clearly set out within the Accountability Letter and up to date policies and procedures.	2, 3	**Reasonable**
5	Effective processes are in place within the Directorates in the setting, delegation, amendment and approval of budgets, ensuring transparency and accountability.	3	**Reasonable**

Findings & Agreed Action Plan

Objective 1: The Trust has an appropriate financial planning approach that aligns the key organisational priorities, available resources and Welsh Government's requirements	**Substantial**

The Trust has consistently demonstrated robust financial planning arrangements, achieving its statutory financial duty to achieve break-even. Reporting to Trust Board (March 2025) noted that, "*there was confidence in delivering around £6.5 million of the required savings, with ongoing work to identify the remaining £2 million*". Further reporting to Finance and Performance Committee (FPC) in July 2025 highlighted that £6.225m of recurrent savings had been identified and £2.275m were deemed non-recurrent. At Month 8 (November 2025), the Trust was forecasting a breakeven position for the 2025/26 financial year end, and that it will deliver the £8.5m savings target.

Audit Wales noted in its Annual Audit report (February 2025) that, "*the Trust has a good understanding of its cost drivers, which include pay, utilities, and service pressures. It makes appropriate use of data from various sources to identify cost-saving opportunities, such as internal reviews and benchmarking. Planning for savings is improving, with a focus on both efficiencies and income generation. The Trust uses a risk-based process to select its cost improvement schemes.*"

Finance remains responsive to the pace and scale of transformational activity, including the Clinical Model Transformation Programme, providing timely costings and support as required.

Financial planning is aligned with the IMTP development process, where a structured project management approach is undertaken. We recently reported on this in our IMTP Development Process audit (report issued October 2025, substantial assurance). This approach ensures that funding is prioritised and allocated to key IMTP deliverables through the MoSCoW (Must have, Should have, Could have, Will not have right now) technique, and that there is involvement from Executive Leadership Team (ELT) and directorate leads in determining key IMTP funding requirements.

There is a clear budget timetable to support delivery of key milestones within the financial planning process. For the 2025/26 financial year, this commenced in November 2024 and included completing the first draft of high-level income requirements for directorates by early December; addressing the savings gap and issuing budget upload files and savings information to budget holders by 28 February; and presenting the Financial Plan to the FPC (18 March 2025) and Board (27 March 2025). This enabled timely submission of the Trust's IMTP, which included the Financial Plan as an appendix, to Welsh Government by the required deadline of 31 March 2025; with formal approval received on 30 June 2025.

The Trust remains at Level 1 (Routine Arrangements) within the NHS Wales Oversight and Escalation Framework and meets annually with Welsh Government to outline its forthcoming financial plan and associated risks. The 2025/26 Financial Plan confirms that, "*the accompanying financial tables and MDS* [Minimum Data Set] *has been produced in line with the guidance received,"* and reflects Welsh Government's minimum 2% savings requirement.

Welsh Government issued its Planning Guidance to the Trust Chief Executive on 20 December 2024 and health boards received their allocation letters for the 2025/26 financial year on 20 December 2024. Whilst the letter does not directly confirm funding for the Trust, it formed the basis of financial planning assumptions including that 1.77% growth funding provided to health boards would be passed through to the Trust in full, as detailed in the allocation letter.

Objective 2: There is clear and robust challenge of the Financial Plan, its assumptions and associated risks by senior management, the Board and its committees, and Welsh Government.	**Reasonable**

Assumptions

Financial assumptions are clearly documented and reported through established governance processes, utilising the Welsh Government guidance and other information available during the planning period. The 2025/26 Financial Plan assumed delivery of up to £8.5m in savings, efficiencies, and cost management, and that the Trust would have full receipt of funding and was underpinned by some externally driven assumptions, including that Welsh Government would fund the costs of the increase in Employer's National Insurance contributions and the forecasted Welsh Risk Pool (WRP) costs as part of the NHS Wales risk-share agreement.

In June 2025, it was confirmed that the National Insurance increase (estimated at £4.69m) would not be fully funded due to a UK Treasury shortfall, limiting the Trust's eligible claim to £3.540m. Additionally, WRP costs rose by approximately £0.9m above forecast. In July 2025, the Board and FPC were advised of these changes, noting a Month 3 year-to-date revenue deficit of £197k. Despite these emerging pressures, the Trust improved its position through targeted actions, including reducing variable pay and lowering sickness absence rates, although the risk of not achieving financial balance remains.

Scenario Planning

Scenario planning is undertaken to support a balanced financial plan and to manage potential risks. Examples provided for 2025/26, included modelling of assumed growth levels and, separately, the financial impact of re-banding Emergency Medical Technicians (EMT). Two scenarios were developed, funded and unfunded, with the latter resulting in a potential £2m deficit (assuming no growth) and requiring an increased savings target of £8.5m to achieve balance.

Contingency and Reserves

The Trust holds an annual £1m contingency budget to manage unforeseen cost pressures, such as winter planning. This is funded recurrently or through increasing savings targets and is reported monthly via internal finance briefings. At Month 7 (2025/26), £502,395 remained uncommitted, with a further £260k committed. The Trust has recognised that the process needs enhancing to demonstrate clear scrutiny and oversight of its application (see **Key Finding 1**).

Reserves are retained centrally and allocated to directorate budgets when IMTP planned developments commence. Regular FPC reporting provides visibility of the Trust's reserves position, which at Month 7 showed a variance of £197k (55.5% above the 5% tolerance for variances), attributed to rebasing 2024/25 balance sheet provisions for annual leave sold.

Governance

An appropriate governance framework is in place which has allowed opportunity for scrutiny of the financial plan. Approximately 90% of the Trust's funding is provided through the NHS Wales Joint Commissioning Committee's (NWJCC) commissioning intentions. We note that the NWJCC is still developing its governance framework, and that formal meeting minutes or papers are not yet available to reflect the monthly updates provided. However, the IMTP submission to Welsh Government was accompanied by a letter of support from the commissioners, noting the Trust's intention to breakeven during the 2025-26 financial year, but that this was not without risk and contingent on delivering a significant cost reduction programme.

We note that Trust senior management were actively engaged in the development of the Financial Plan through participation in workshops and events held between October 2024 and February 2025, linked to both the IMTP and financial planning processes, to assist with prioritisation of funding requirements. Updates were provided at Executive Finance Group (EFG) and Executive Leadership Team (ELT).

Our IMTP Development Process audit highlighted that an early draft of the IMTP was originally intended for Non-Executive Directors (NEDs) by the end of January 2025, but in practice, reporting occurred in early March 2025 following a decision not to share an incomplete draft. We have been unable to ascertain when an early draft version of the Financial Plan was shared with the NEDs. Despite this, Trust Board and FPC received regular updates of the Plan's development and in line with the agreed timeline. The Plan was presented to FPC on 18 March 2025, and the Trust Board formally approved the IMTP and its appendices, including the Financial Plan, on 27 March 2025. The NEDs acknowledged the ambitious and potentially transformational nature of the Plan, and the potential impact on service delivery and patient safety, given the efficiency targets of £8.5 million and the risks linked to any additional savings that may be requested by the NWJCC.

Key Findings		Risk & Impact	Agreed Management Action
1	**Contingency Budget** The Trust maintains a £1m contingency provision; however, the governance arrangements over its application require strengthening to ensure sufficient scrutiny and oversight. Requests for contingency funding are submitted to either the Executive Finance Group (EFG) or Executive Leadership Team (ELT), but formal approval of these allocations could not be clearly demonstrated, despite the Trust strengthening the governance arrangements around the utilisation of funds in August 2025. Although the contingency is referenced in the Financial Plan and reported annually to the Board, greater oversight of its deployment is needed. This should include alignment with the reporting of Trust reserves, and ensuring any significant change to its value is supported by documented rationale.	Without clear and consistently documented scrutiny and approval of contingency allocations, funds may be used inconsistently or without full transparency.	**Agreed Action:** Management will formalise and document a clear process for approving and recording contingency budget allocations via the Executive Director of Finance & Corporate Services as its Budget Holder. This will include using a standard request/approval record and ensuring decisions are consistently reported within its monthly internal governance finance reports. **Expected Evidence of Implementation:** • Standardised contingency request/approval record. • Summary included within current internal governance finance reports.
		Medium Priority	**Officer:** Jason Collins, Head of Financial Management **Target Implementation Date:** 31 July 2026
	Theme: Finance Management & Control	Control Design	

Objective 3: Budget holders are effectively engaged at an early stage and supported throughout the budget setting process, and the Trust has sufficient internal resources, skills and systems to enable effective budget planning	**Reasonable**

The internal audit review of Savings and Efficiencies (report issued May 2023 – Reasonable Assurance) highlighted the need for all budget holders to receive formal financial training. Similarly, the Audit Wales review of Cost Savings Arrangements (August 2024) noted the need to strengthen financial literacy and competencies across all staff levels within the Trust to support financial sustainability.

Action has been taken to improve the financial awareness of budget holders through the provision of presentations, verbal guidance, and emailed resources, e.g. Budget Manual and Delegated Budget Holder expectations. However, no recent formal training has been provided, particularly for new budget holders (see **Key Finding 2**). We note, however, that the Finance Academy is working with NHS organisations to enhance training provision nationally. Finance training materials are available on Siren, though content would benefit from a review (see **Key Finding 2**).

Budget holders benefit from access to the QlikSense dashboard through the NHS Wales national programme, which alleviates the need for issuing monthly budgetary reports and enables real-time financial visibility. However, dashboard training and ongoing support could not be evidenced, and there is no routine oversight to ensure the tool is being utilised effectively (see **Key Finding 2**). Routine monitoring of dashboard usage would help target support and reduce reliance on manual budget reports.

Despite these gaps, Finance maintains strong internal engagement practices, within the financial planning stage (see Objective 1). Directorate-level support is well embedded during the budget setting process, including Finance representation at senior leadership team meetings and providing informal weekly financial updates. Evidence was provided of examples where budget holders were formally notified of their budgets. Discussions with a sample of budget holders (see details in *Objective 5*) expressed their appreciation for the support and guidance provided by Finance.

We recognise that budget holders will have competing priorities, including the Clinical Model Transformation Programme, which places additional operational pressures on managers as well needing to prioritise service delivery, and their capacity could impact their level of engagement in the budget-setting process for 2026/27.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Financial Training Provision** Both the Standing Financial Instructions (SFIs) and the Budget Manual reinforce the requirement that budget holders receive ongoing training. However, no recent structured financial training has been delivered, and there is no evidence confirming budget holders' competency. Where resources are emailed to budget holders, only 40% of 122 budget holders have completed a Microsoft Form to confirm their understanding. Some finance training resources were not available on Siren, and the Budget Manual is located under 'Meet the Teams-	Insufficient financial training and lack of competency assurance may lead to inconsistent budget management and reduced compliance with SFIs, weakening financial control and	**Agreed Action:** Management will: • Update and centralise training materials on Siren. • Introduce routine monitoring of QlikSense usage to target support. • Records should be maintained to confirm where financial training has been provided. • Explore development of training across NHS Wales, perhaps by the Finance Academy.

Key Findings		Risk & Impact	Agreed Management Action
	Financial Management' rather than 'Training/ Guides/ Procedures', limiting accessibility. While 92 users have received QlikSense dashboard training, only 45% have accessed the system over a 90-day period (July – October 2025).	increasing the risk of errors.	**Expected Evidence of Implementation:** • Updated and accessible training materials on Siren. • Training records confirming completion by all budget holders. • QlikSense usage monitoring reports and evidence of follow-up support.
		Medium Priority	**Officer:** Jason Collins, Head of Financial Management **Target Implementation Date:** 31 December 2026
	Theme: Training & Development	Control Design	

Objective 4: Roles and responsibilities and the arrangements for budget setting are clearly set out within the Accountability Letter and up to date policies and procedures.	**Reasonable**

Roles and responsibilities are clearly documented within the SFIs (approved September 2025) and align with the NHS Wales model. The Budget Manual (2025/26), which is updated annually, and the '*Budget Holder Training Setting Expectations*' material, also outline key responsibilities and arrangements for budget setting and delegation. Both resources are distributed as part of the budget holder training pack, although, as noted in **Key Finding 2**, there is an opportunity to improve their accessibility on Siren.

The budget timetable outlined that budget books were due to be approved by Executive Directors by 30 May 2025. However, we note the accountability meetings between the Chief Executive, Director of Finance, and Executive Directors had to be extended into July due to scheduling challenges. We are not aware that this delay had a significant impact on the overall budget process. Given that the financial outlook for 2026/27 is expected to be more challenging, it will be increasingly important for the Trust to meet this deadline in future.

Clause 5.2.1 of the SFIs states that, "*the Chief Executive may delegate, via the Executive Director of Finance and Corporate Resources, the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of: a) The amount of the budget; b) The purpose(s) of each budget heading; c) Individual or committee responsibilities; d) Arrangements during periods of absence; e) Authority to exercise virement; f) Achievement of planned levels of service; and g) The provision of regular reports. The budget holder must sign the accountability letter formally delegating the budget*." The Budget Manual reinforces this requirement.

There is strong engagement at Executive Director level in reviewing budgetary priorities and associated risks, and the delegation process is understood. However, it lacks formal written accountability that has been seen at other NHS organisations, which presents an opportunity to strengthen existing arrangements to ensure compliance with the SFIs and Budget Manual and provider clearer assurance over budget accountability (see **Key Finding 3**).

	Key Findings	Risk & Impact	Agreed Management Action
3	**Strengthening the Formal Budget Accountability** Budget books are issued to Executive Directors and reviewed through face-to-face meetings, with agreement confirmed by email. However, this confirmation relates to meeting notes rather than a formal accountability statement. Similarly, there is no evidence of written delegation from Executive Directors to budget holders within their directorates (see **Objective 5**).	Unclear accountability increases the risk of inconsistent budget management and non-compliance with the SFIs and Budget Manual, reducing assurance that budget responsibilities are fully understood and applied.	**Agreed Action:** The Trust will introduce formal written budget-delegation arrangements at both Executive Director and budget-holder level, ensuring documentation aligns with the requirements of the SFIs and Budget Manual to confirm budget accountability. **Expected Evidence of Implementation:** • Signed budget accountability for all Executive Directors. • Signed budget delegation within each directorate. • Confirmation that the process has been embedded in the annual budget timetable.

Key Findings		Risk & Impact	Agreed Management Action
		Medium Priority	**Officer:** Jason Collins, Head of Financial Management **Target Implementation Date:** 31 July 2026 (Executive Director sign-off); 31 August 2026 (all other budget holders)
	Theme: Finance Management & Control	Control Operation	

Objective 5: Effective processes are in place within the Directorates in the setting, delegation, amendment, and approval of budgets, ensuring transparency and accountability.	**Reasonable**

Budget Setting

The Trust's budget-setting process is evolving from traditional incremental budgeting towards a combined bottom-up and top-down approach, ensuring greater ownership and accountability among managers. While budgets need to be set within forecasted income levels, we were advised that zero-based budgeting has been adopted in some areas to ensure resources are allocated more effectively. We note that the Digital Directorate has utilised it, but that Operations has not yet had the opportunity to consider its use (see the suggested enhancement noted in the Executive Summary).

Budget setting usually begins in November, initially focussing on income before taking account of pay and non-pay costs. For 2025/26, draft budgets were shared by the end of February 2025 and uploaded into the financial system during April, in line with the agreed budget timetable. Their upload process is comprehensive, with budgets journals reconciled to control totals for the financial year. We were advised that budget amendments are permitted if funding is received or to take account of service restructures.

Budget Delegation and Approvals

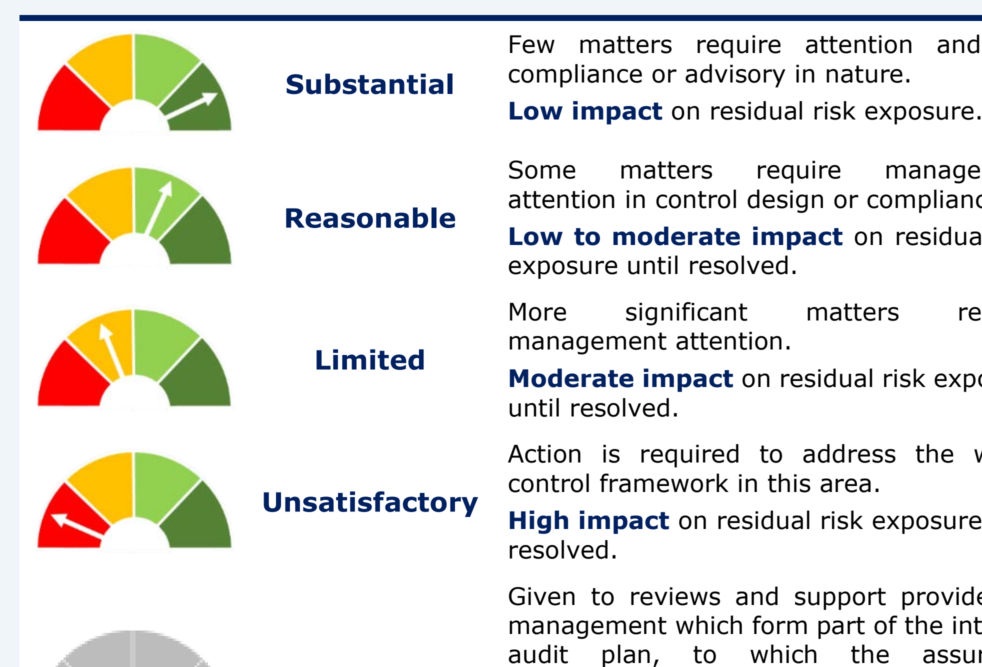
The Scheme of Reservation and Delegation of Powers (Schedule 1) details that (p40), "*unless otherwise stated, sub-delegations to others are permitted. It is for individual Directors to ensure that a system of sub-delegations is in place for their respective directorates. This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs. Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated*."

Similarly, Clause 5.2.6 of the SFIs details that, "*all budget holders will sign up to their allocated budgets at the commencement of the financial year*." Our testing of two directorates (Operations and Digital Services directorates) highlighted an opportunity to strengthen documentation of formal delegation approval from Executive Directors to budget holders (see **Key Finding 3**).

Delegated financial limits are clearly defined within Schedule 1, and the receipt of an authorised signatory form prompts the configuration of these limits within the Oracle finance system. Testing of four directorates (Operations, Digital Services, Strategy, Planning and Performance, and Quality, Safety and Patient Experience) confirmed that while there was some variation in how delegated limits are applied, the limits were consistent with that detailed in Schedule 1 and aligned to the authorised signatory form.

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion



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

Prioritisation of Findings

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

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

Disclaimer

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

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

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

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

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.

Clinical Model Transformation Programme

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust

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Audit Committee	2 March 2026
Executive Lead	Rachel Marsh, Executive Director of Strategy, Planning and Performance
Audit Team	Osian Lloyd, Head of Internal Audit
	Felicity Quance, Deputy Head of Internal Audit

Executive Summary

Purpose

To undertake a high-level review of the governance arrangements established for the Clinical Model Transformation Programme to ensure that each identified workstream is managed effectively as a formal strategic change initiative. This included assessing whether appropriate assurance and reporting mechanisms are in place to support oversight, accountability, and informed decision-making.

Overview

The Clinical Model Transformation Programme (CMTP or 'the programme') was established to deliver a unified approach to transformation within Welsh Ambulance Services University NHS Trust ('the Trust'), shifting from a clinical response model to an integrated clinical services model. This evolution aims to improve patient outcomes through better prioritisation and expanded community-based care. Key drivers for change include avoidable patient harm, managing rising demand, addressing workforce pressures, and meeting statutory obligations under the Duty of Quality Act.

A Programme Definition Document (PDD) and individual workstream plans[1] provide frameworks for delivery, supported by programme and digital planning tools established by the Transformation Support Office. These tools enable structured planning and progress tracking; however, visibility of milestone changes and mapping of cross-workstream dependencies could be strengthened as implementation advances.

Roles and responsibilities are well-defined, escalation routes are in place, and reporting to governance forums is consistent. Highlight reports and consolidated programme updates are provided to the Clinical Model Transformation Board ('the CMT Board') and onward through the Trust's governance structure. Recent improvements in reporting content and the inclusion of appendices at committee level have enhanced transparency, though milestone tracking remains largely activity-based rather than outcome-focused.

Early internal evaluations indicate positive impacts, including improved triage efficiency, reductions in unnecessary conveyances, and better patient outcomes. A three-year external evaluation by Edge Hill and Swansea University is planned. However, the Trust must prioritise the creation of a benefits register and implementation of benefit scorecards, which are essential to demonstrate programme impact These actions have been delayed due to the need to prioritise recent changes related to the Ambulance Performance Framework.

We have concluded **reasonable** assurance over governance arrangements. The matters requiring management attention include:

- Complete benefit measurement tools, cross-workstream dependency mapping and closure arrangements as the programme moves into Phase 3; ensure deliverables are clearly defined and improve milestone visibility.
- Share the Programme Definition Document beyond the programme structure to provide wider assurance to stakeholders.

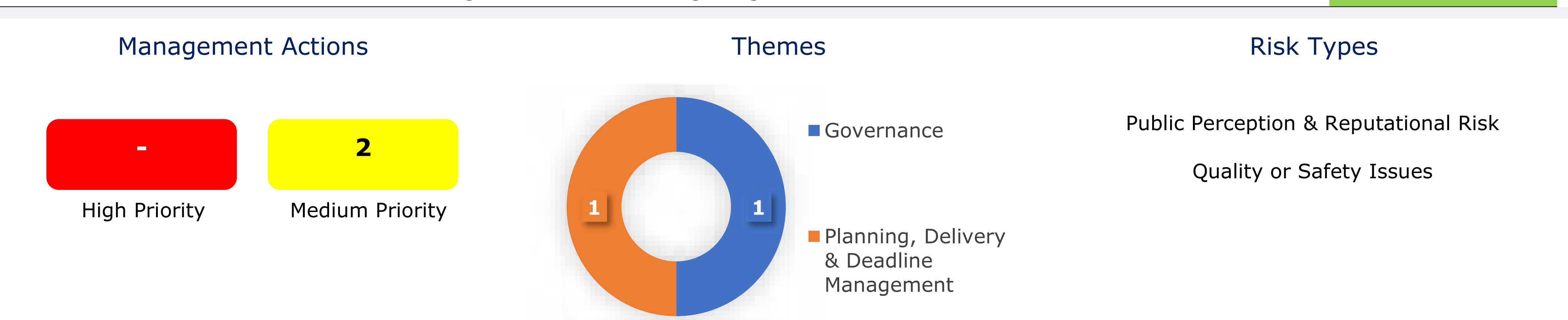
Full details of matters arising are detailed within the Findings & Agreed Action Plan. During the course of audit fieldwork, we noted that the distinct role profiles for Executive Sponsors and Senior Responsible Officers within the programme had been drafted but not yet finalised (see *objective 2*). These will be completed as part of the Phase 3 workshops scheduled for early 2026. Following this, there is an intention to update the 'Project Path Framework', the Trust's model for programme management, to incorporate these profiles. We have highlighted this point for management information; it does not impact the overall audit opinion.

[1] The programme is delivered through five core workstreams: Digital Front-End, which provides integrated online advice and navigation; Remote Integrated Care, offering multi-professional remote assessment and referral; Urgent Community Response, delivering specialist community-based urgent care; Emergency Response Service, focussed on clinically prioritised call screening and rapid dispatch; and Health Transport which coordinates integrated planned transport for non-urgent care.

Scope & Assurance Summary

Objectives *The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.*

	Objectives	Related Findings	Assurance
1	The programme has established clear measures of success and key milestones aligned to its five core workstreams.	1, 2	**Reasonable**
2	Roles, responsibilities and ownership are clearly defined across all programme workstreams to support effective delivery and oversight.	-	**Substantial**
3	Progress is regularly monitored against defined measures and milestones, with active engagement from enabling workstreams, internal functions, and external partners, and appropriate escalation mechanisms in place.	2	**Reasonable**
4	Performance and progress against the programme's objectives are reported to the Trust Board and relevant committees to ensure effective governance and strategic alignment.	2	**Reasonable**



At A Glance: Chronology of Major Changes presented to the CMTP Board (December 2025)

Timeline of Major Changes Under the Governance of the Clinical Model Transformation (CMT) Programme

Evolving Clinical Services Model

The Clinical Model Transformation (CMT) Programme is a clinically-led initiative to evolve our Clinical Services Model. It aims to improve patient flow through greater integration, enhanced clinical pathways, and timely, appropriate care. Through a phased approach, the programme has introduced a series of changes to better align care delivery with need, reduce avoidable conveyance, and expand remote and community-based interventions.

In parallel, the Welsh Government launched a national review of ambulance targets in late 2024. While externally led, the implementation of the revised Ambulance Performance Framework (APF) and related changes falls within the scope of the CMT Programme.

The timeline presents key milestones in the evolution of our Clinical Services Model, including go-live dates for operational changes aligned to the revised APF. These developments mark a significant shift towards delivering safer, more responsive, and clinically effective care across Wales.

May 24

Programme Initiation

Programme launched under the oversight of the Clinical Model Transformation Board.

Jul 25

DoS Improvement

Alternative **pathway access standardised** for all remote clinicians across 111 and the Clinical Support Desk.

Tests of Change for APP Scheduling

Testing **feasibility of scheduled APP face-to-face appointments** for 999 patients needing clinical assessment.

Sep 24

Tests of Change for CPSS Management of 999 Calls

Tests of change began to **assess if 111 call handlers using CPSS can manage more cases**, including Green ambulance waits.

Nov 24

Mental Health Response Vehicle Launched

Mental Health Response Vehicle introduced in the Southeast to offer in-person care from mental health clinicians for 999 calls.

Nov 24

Rapid Clinical Screening (RCS) Launched

Phased **transition of key CSD functions to Rapid Clinical Screening**, including Remote Clinical Support, Queue Safety Reviews, High Acuity Reviews, and CSP Escalation.

Dec 24

RCS for Amber 2 Calls

Rapid Clinical Screening introduced for Amber 2 calls. CSP updated to v3.3, removing 'can't send' advice except at CSP 4B.

Remote Integrated Care Enhancements

- **Care Planning Desk launched**, offering personalised clinical case management and remote monitoring for complex patients.
- **CPSS formally adopted for triaging low acuity 999 codes** following successful trials in September 2024.
- **Winter desk launched**; 111 Call Handlers began pulling 999 calls awaiting triage to manage them via CPSS.

RCS for Green Calls

Rapid Clinical Screening implemented for Green calls to identify cases suitable for remote assessment. 'No send' advice at CSP 3A withdrawn to reduce unmet care needs.

Feb 25

RCS for Amber 1 Calls

Rapid Clinical Screening extended to Amber 1 calls to identify cases suitable for remote assessment.

Remote Integrated Care Enhancements

- **Trial of Luscii Remote Monitoring launched**, enabling Community Welfare Responders to capture observations for review by Care Planning Clinicians.
- New **warm transfer process** introduced for 111 staff managing Amber 2 and Green calls.

Jul 25

Ambulance Performance Framework Phase 1

Purple Arrest, Red Emergency, and RCSO categories introduced to enhance call prioritisation and improve response to cardiac and respiratory arrest.

NHS 111 Wales Virtual Assistant

'Albot' virtual assistant launched to help users find answers to common queries across the website.

Dec 25

Ambulance Performance Framework Phase 2

New Rapid Clinical Screening categories introduced: Orange Now, Yellow Soon, and Green Planned, to refine prioritisation.

Findings & Agreed Action Plan

Objective 1: The programme has established clear measures of success and key milestones aligned to its five core workstreams. **Reasonable**

Governance and Programme Documentation

The Programme Definition Document (PDD) sets out the programme's scope, governance arrangements, phased delivery timelines, and control mechanisms (see page 3 for a chronology of programme milestones). The PDD was first presented to the CMT Board in November 2024, approved by Strategic Transformation Board (STB) in January 2025, and updated to version 2.1 in September 2025. Although approved by both boards, we could not confirm its circulation to Non-Executive Trust Board members or presentation outside programme forums (see **Key Finding 1**).

The PDD defines three delivery phases:

- Phase 1 – Six critical projects prioritised for winter readiness.
- Phase 2 – Embedding the Integrated Clinical Services Model across all workstreams through process standardisation and sustainable improvements.
- Phase 3 – Longer-term optimisation, culminating in programme closure by April 2027.

During Phase 2, the programme adopted digital tools to strengthen oversight of planning (see delivery planning section below) and maintain programme logs (risk, action, decision, and issue registers).

Workstream Definition Documents (WDDs) have been drafted for the five core workstreams, with enabling groups operating under CMT Board-approved Terms of Reference. We selected Emergency Response Service (ERS) and Remote Integrated Care Service (RICS) for in-depth review. WDDs for these workstreams demonstrated consistency in format and content, including vision statements, objectives, outputs (e.g., recruitment, revised scopes of practice), outcomes (e.g., increased capacity, improved coordination), and indicative benefits. Formal approval of WDDs by the CMT Board commenced recently, with RICS approved in December 2025, reflecting the iterative nature of deliverables across programme phases. Approval of the remaining workstreams is expected in early 2026.

We reviewed project-level specifications for Rapid Clinical Screening (RCS[2]) within the ERS workstream, and the Process and Digital project groups within the RICS[3] workstream. These specifications follow a logical structure covering scope, outputs, and benefits, with variations reflecting operational priorities. However, benefits and indicative Key Performance Indicators (KPIs) are referenced without supporting baseline data or defined targets (see benefits section below). Additionally, while both the Process and Digital groups are responsible for the Care Planning[4] deliverable, the outputs and benefits specific to Care Planning were not clearly articulated within their respective specifications (see **Key Finding 2**).

Delivery Planning and Interdependencies

Following an initial five-day workshop in May 2024 to determine the programme approach for Phase 1, Phase 2 workshops have been used to develop and refine deliverables which then underpin workstream plans. While the programme has set April 2027 as the target date for delivering

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[2] With RCS, Clinical navigators assess whether a patient requires an on-scene response, identify the most appropriate resource, or refer the case for secondary triage.

The RICS structure was revised between Phase 1 and Phase 2, moving from five groups and 14 task-and-finish teams to a more streamlined model. Current RICS specifications align to its four core groups; Process, Digital, People & Culture, and Clinical and Professional Practice.

[4] Care Planning provides personalised clinical case management for patients with complex health needs who have accessed WAST services. This approach aims to deliver care closer to home in collaboration with advanced practitioners, community services, and health board pathways, until transfer to the most appropriate provider.

a fully Integrated Clinical Services Model, detailed plans with defined deliverables for Phase 3 are not yet available as workshops are scheduled for early 2026.

Programme planning tools are utilised across multiple levels:

- Workstream level – "Plan on a Page" and phase (Miro format) plans highlighting critical deliverables and dependencies.
- Task level – MS Planner software is used for detailed breakdowns of actions, assigned at individual level with target dates aligned to milestones. This has replaced the previous excel based template used in phase one.

Review of the project level plans for RCS (within the ERS workstream) and Process and Digital groups (within RICS workstream) found consistency in mapping milestones across the formats. Within RICS, group plans were iteratively updated to reflect delays in integrating the Computer Aided Dispatch (CAD) system between the 111 and 999 services.

Cross-workstream dependencies are noted in phase and task-level plans, but consolidation into a single view has been paused with no revised delivery date (see **Key Finding 2**). The PDD does not define transition or handover arrangements should actions remain outstanding at programme closure, and we are informed that these will be discussed as part of the Phase 3 workshops scheduled for early 2026. As detailed in *objective 3* of the six initial Phase 1 projects, only one (RCS) is considered closed.

Benefits Realisation and Success Measures

The programme uses a standardised benefits realisation approach, approved by the CMT Board in November 2024, incorporating Logic Benefit Maps (LBMs) that link inputs, activities, outputs, and outcomes to defined benefits and indicators within scorecards combining qualitative and quantitative measures.

LBMs have been developed and approved for each workstream but implementation of scorecards remains in progress. The scorecard format, aligned to four domains (patients, staff, value, and system contribution), was endorsed by the CMT Board, with initial drafts shared in May 2025. Some indicators are long-term and unlikely to be readily reportable, while staff perception measures will require bespoke data collection.

Development of these scorecards, including a consolidated programme scorecard in Power BI, has been delayed due to capacity constraints within the Data and Analytics team, as priority has shifted to reporting for the new Ambulance Performance Framework (see **Key Finding 2**). A draft Benefits Realisation Plan, which includes the development of a single programme Benefit Register, is scheduled for discussion at the December 2025 CMT Board, with endorsement expected in January 2026.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Limited Circulation of Programme Definition Document** The Programme Definition Document (PDD), which sets out the programme's scope, governance, and phased delivery timelines, has been approved by the CMT Board and Strategic Transformation Board. However, we could not confirm its circulation to Non-Executive Trust Board members or presentation outside programme forums. While we recognise the need to balance the level of detail provided to Non-Executive Directors, this programme represents a significant change to the Trust's response model. In this	Restricted organisational visibility may reduce assurance over strategic alignment and governance compliance at Board level.	**Agreed Action:** *Circulate the current approved PDD (v2.1 or latest) to the Finance & Performance Committee, ensuring formal "for assurance/noting" agenda placement at the earliest available cycles.*

	Key Findings	Risk & Impact	Agreed Management Action
	context, sharing detail of the outputs and outcomes that sit beneath the headline objectives within the PDD would provide valuable clarity on the intended impact and delivery expectations.		**Expected Evidence of Implementation:** *Committee agendas and minutes showing the PDD as an item*
		Medium Priority	**Officer:** Gareth Taylor, Programme Manager, Transformation Support Office **Target Implementation Date:** 30 September 2026
	Theme: Governance	Control Design	
2	**Programme Planning and Delivery Gaps** This review was conducted at approximately the mid-point of the programme's implementation. Programme capacity has been impacted by the need to prioritise resources for the Ambulance Performance Framework, particularly digital capability. While documentation and digital tools are largely in place, further progress and consistency are required. We have consolidated these matters into a single finding to reflect their cumulative effect. **Programme documentation**: Sample testing identified that the Care Planning deliverable within the RICS workstream lacked clearly defined outputs and outcomes traceable within programme specifications (2a). **Programme tools**: • Benefit Scorecards: benefits have been articulated across programme, workstream, and project documentation; however, these have not yet progressed to include baseline data, defined targets or timescales, nor have they been integrated into formal reporting tools (2b). While development of a Programme Scorecard is forecast for early 2026, and workstream scorecards are to follow, the Programme Benefits Register that will underpin these tools has not yet been established (2c). • Cross Dependency Mapping: a consolidated view of workstream interdependencies has not been developed. While initial mapping has commenced and is reflected	Without addressing these gaps, there is an increased risk of inconsistent programme implementation, leading to delays, duplication of effort, and reduced ability to track progress and demonstrate achievement of intended benefits and outcomes are within planned timescales. This could undermine strategic objectives and erode stakeholder confidence.	**Agreed Action:** *2a). Following Phase 3 workshops review Workstream Definition Documents to ensure each deliverable can be mapped to associated outputs, outcomes, and benefits.* *2b). Following the population of the Benefit Scorecards, incorporate these within the Programme Highlight Report format.* *2c). Progress the development of a Programme Benefit Register to include baseline, target, due date, and data source.* *2d). Create one consolidated dependency map covering all critical interdependencies, with owner, impact, mitigation.* *2e). Not Agreed: Enabling Groups manage plans via preferred methodology/software. Progress Tracking via existing reports into CMT Board.* *2f). Complete the RCS project closure report containing achievements, lessons, and status of any residuals or carried forward actions.* *2g). Programme Management Report to CMT Board to collate baseline date, current forecast, variance, and reason for the key workstream milestones.* **Expected Evidence of Implementation:** *2a). Updated Workstream Definition Documents demonstrating the linkage between deliverables and outputs, outcomes and benefits.*

Key Findings	Risk & Impact	Agreed Management Action
within individual plans, no timescale has been agreed for completion (2d). • Plan consistency: a Programme Engagement Plan has been established to direct and monitor internal and external communications. The current use of an Excel-based format could be digitised for consistency with other programme tools (2e). **Closure Planning & Reporting:** Transition or handover arrangements for programme closure are yet to be defined, with only one of the six initial Phase 1 projects (RCS) has been formally closed, and a project closure report is still to be developed with absences within the project team contributing to its delay. The RCS project plan included some actions deferred or noted as out of scope for that phase; the closure report will provide an opportunity to confirm whether these have since been addressed (2f). **Progress Reporting & Milestone Visibility**: Highlight reporting focuses on current and intended activity, with limited inclusion of outcomes (see 2b). While programme tools support monitoring, reporting does not clearly reflect progress against original milestones, limiting the ability to track slippage (2g).	**Medium Priority**	*2b). Updated Highlight Report Format which includes populated Scorecards inclusive of Patients, Staff, Value, System domains.* *2c). Programme Benefit Register containing entries for each workstream including baseline, Target, Due date, Status, Data owner.* *2d). Published Programme dependency map/register.* *2e). Removed as per comment above.* *2f). RCS closure report received by CMT Board.* *2g). Programme Management highlight report template with baseline/variance columns.* **Officer:** Gareth Taylor, Programme Manager, Transformation Support Office **Target Implementation Date:** 31 March 2027
Theme: Planning, Delivery & Deadline Management	Control Operation	

Objective 2: Roles, responsibilities and ownership are clearly defined across all programme workstreams to support effective delivery and oversight.	**Substantial**

Programme-level roles are documented within the PDD, which identifies the Programme Executive Sponsor (Trust CEO), Programme SRO (Director of Strategy, Planning and Performance), and Senior Programme Manager (Head of Transformation). Section 6.7 of the PDD includes a full listing of Executive Sponsors and SROs for all workstreams and enabling groups, supported by a RACI (Responsible, Accountable, Consulted, Informed) matrix to clarify responsibilities.

The Trust's Project Path Framework outlines generic project management roles but combines the definitions of SRO and Executive Sponsor. Following Phase 1 of CMTP, separate profiles were drafted, but finalisation was paused when the SRO assumed interim CEO duties. Completion is planned within Phase 3 workshops, and this action is noted on the CMT Programme Action Log.

Review of the PDD and Programme Board Terms of Reference confirms alignment of governance and delegation arrangements. The CMT Board discussed delegation, with emphasis placed on agile, locally informed decision-making. Strategic oversight remains with the CMT Board, while operational decisions are devolved to workstream and project-level SROs. Escalation routes and membership structures are documented, and workstream and project-level documents reviewed confirm this alignment.

CMT Board minutes (February–September 2025) confirmed quorum and consistent representation across workstreams. Workstream-level attendance records are limited, as SROs manage local arrangements. RICS began recording minutes in July 2025, all of which were quorate. A sample review of Teams logs for four Call Categorisation project meetings also confirmed quorum.

The Change Management workstream experienced engagement challenges including inconsistent identification of Change Leads and low attendance, noted in 'Alert, Advise, Assure' (AAA) reports to the CMT Board. Membership was expanded to include SROs from RICS, ERS, and Digital Front End, which improved participation. Our review of terms of reference and definition documents identified where no lead was documented. Where this was the case we confirmed the SRO or project lead attended the overarching Change Group. This was fed back to the programme team for correction at the date of audit fieldwork; therefore no recommendation is raised.

Objective 3: Progress is regularly monitored against defined measures and milestones, with active engagement from enabling workstreams, internal functions and external partners; and appropriate escalation mechanisms in place.	**Reasonable**

Monitoring Framework

The programme has established a structured approach to monitoring progress through digitised planning tools (see objective 1) which are regularly presented in workstream and project meetings to indicate respective status and upcoming milestones. A review of MS Planner entries at the end of October 2025 noted 774 tasks populated across the five core workstreams. Of these, 406 tasks have been completed, 52 marked as late (although this includes tasks since completed, paused, or considered 'should do'), 12 in progress, and 305 were yet to be started. A formal change log is maintained to capture the rationale and approvals for process, team, and system changes.

Workstream plans are mapped in Miro and shared with the CMT Board when significant delivery changes occur. Highlight reports provide sequenced updates on completed and planned activity, with each project and workstream assigned an individual RAG rating. While this supports visibility of current status, the format offers limited transparency against original target dates (see **Key Finding 2**). Discussion with programme management indicated that in adapting to evolving priorities has required some flexibility in milestone monitoring.

Enabling workstreams report using the AAA template, with outputs (e.g. communication plans, status of data analytic tools or reports) shared regularly.

Project-Level Monitoring

Two sampled areas were reviewed:

- RCS (ERS Workstream): Milestones were tracked through key deliverables such as Clinical Navigator recruitment, phased go-live approvals, technical developments (e.g., CAD configuration), and governance checkpoints (project initiation/specification, group terms of reference, Quality Impact Assessment (QIA) completion). Progress was monitored via a colour-coded Gantt chart with dated commentary on decisions, dependencies, and delays. Items identified as out-of-scope (e.g., Call Flow Categorisation) were deferred for future projects, but a formal project closure report has not been produced with the recent absence of ERS project support contributing to this (see **Key Finding 2)**.
- Care Planning (RICS Workstream): Delivered jointly by the Process Group (care planning design) and Digital Group (remote monitoring enablement). Responsibilities were mapped in Miro, with progress consolidated into highlight reports. Initial Phase 2 plans for service metrics and evaluation from May 2025 were revised after a workshop identified the need for clearer roles and criteria. Complex case prioritisation was agreed, with actions raised on training and process review reflected in highlight reports.

Interim Evaluations

Although benefit scorecards are not yet available to measure programme impact formally, several interim evaluations have been undertaken to assess effectiveness and inform future delivery:

- RCS (ERS Workstream): Early evaluation demonstrated strong impact on triage efficiency, with approximately 75% of incidents suitable for remote assessment. Between November 2024 and January 2025, this contributed to a reduction of around 4,000 conveyances and an increase in consult-and-close rates from approximately 15% to 20% (November 2024 – August 2025).
- Care Planning (RICS Workstream): Proof of concept for remote monitoring using Luscii (remote monitoring technology) achieved 36% resolution without attendance and 69% managed via consult-and-close or referral. However, challenges were noted in data capture and system interoperability, which require further mitigation.

- Winter Desk Trial (RICS Workstream): Testing Band 3 call handlers with the Call Prioritisation Streaming System for 999-originated calls resulted in 30% of cases resolved without escalation and delivered notable cost efficiencies compared to higher-band clinicians.
- Mental Health Response Vehicle (UCR Workstream): Evaluation indicated improved patient outcomes, with conveyance to Emergency Departments reduced to 16% (versus 45% for traditional ambulance resources) and a 69% consult-and-close rate for responded calls. Positive feedback was also received from staff and system partners.
- Staff Survey – Ambulance Performance Framework (Phase 1): Over 400 responses highlighted mixed perceptions - while patient prioritisation was viewed positively, only 46% felt it improved experience and 34% believed it enhanced care. Findings were shared via WAST Live, and subsequent changes to solo response codes were implemented.

In addition, the Trust has commissioned an external evaluation by Edge Hill and Swansea Universities to provide independent assessment of call categorisation changes and programme impact over a three-year period. Evidence gathering commenced in November 2025.

Risk escalation

The programme has implemented a formal Risk and Issue Management Standard Operating Procedure (SOP), supported by a digitised risk log maintained within MS Lists. Risks are reviewed at least every 60 working days, and at the date of audit fieldwork, no overdue reviews were identified. The programme risk log contained 150 entries, of which 101 had been closed. We sampled five high-scoring risks (rated 16+) and confirmed that closure was supported by appropriate commentary and mitigation. While the current MS Lists format limits consolidated visibility across workstreams, development of Power BI dashboards is planned to further enhance reporting and enable drill-down capability at programme, workstream, and project levels.

Programme Engagement and Communication

The Programme Engagement Plan (PEP) sets clear objectives for informing and involving internal and external stakeholders. Engagement activities include targeted sessions with Welsh Government, health boards, clinical advisory groups, and broader stakeholder outreach, plus organisation-wide updates every 4–6 weeks and workstream-specific communications. The PEP outlines proactive engagement tools such as briefing packs, bilingual FAQs, and video explainers, though some workstream entries remain “TBC” because these workstreams are at different stages of development and have not yet required specific FAQs; these will be produced as changes progress.

The internal communications plan, initially managed under the Change Management workstream, was transferred in June 2025 to the Partnerships & Engagement workstream to consolidate internal and external communications and strengthen delivery. An update to the PEP and development of an internal communications plan are planned. Consolidating these actions within MS Planner would support improved visibility and monitoring of progress. (see **Key Finding 2**).

Objective 4: Performance and progress against the programme's objectives are reported to the Trust Board and relevant committees to ensure effective governance and strategic alignment.	**Reasonable**

The programme operates within a six-week business cycle guided by a SOP, which sets expectations for reporting and escalation, providing structured oversight through the CMT Board, STB, and Finance & Performance Committee (FPC).

Programme reporting is primarily delivered through standardised highlight reports in PowerPoint format, enabling consistent presentation across workstreams. Reports reviewed generally follow a common structure, though minor variations in terminology were noted (e.g. RICS reports by deliverable, others by project or group). Despite these differences, reports provided sufficient context for RAG ratings and key developments. Variability in detail reflects differences in scope and stage of progression.

Review of CMT Board agendas for the period February–September 2025 identified very few verbal updates, indicating that governance processes are embedded and supported by the structured reporting mechanisms. Each meeting's highlight reports were accompanied by a consolidated Programme Report summarising progress in development of assurance mechanisms and key documentation such as QIAs. For the period reviewed, Programme Management and overall Programme ratings were consistently yellow, signalling anticipated challenges but no material impact on delivery. However, milestone tracking remains largely narrative-based, with references to "underway" or "planned" rather than specific deadlines, reducing visibility against original baselines (see **Key Finding 2**).

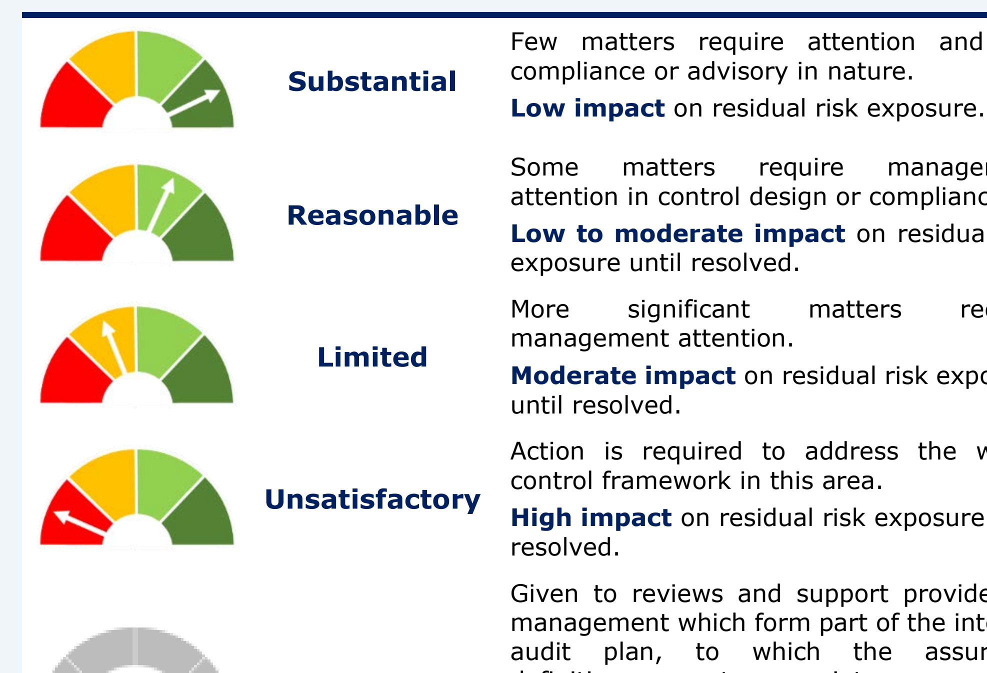
Reporting to the FPC and onward to the Trust Board has matured, evolving from high-level narrative updates to detailed workstream reporting with RAG ratings. The inclusion of highlight report appendices from July 2025 onwards, in response to Non-Executive Director requests, represents a positive development improving both consistency and transparency.

In November 2024 QUEST approved the mechanism by which the programme develops QIAs, involving Clinical Advisory Group (CAG) review followed by Clinical Quality Governance Group (CQGG) approval. QIAs are then shared with the CMT Board and STB for assurance, and the Programme Definition Document states they will also be shared with QUEST for information. Review of QUEST agendas showed only the UCR QIA was presented in May 2025. We were advised that decisions on further presentation of QIAs beyond the programme and STB rest with Clinical Directors as CQGG chairs. Additionally, although not programme-initiated, the Ambulance Performance Framework and its second phase have appeared in QUEST reporting, including QIA and EQIA reviews and operational readiness.

The Trust has introduced an Integrated Governance Programme to standardise and strengthen governance arrangements, promoting consistency, transparency, and accountability across all levels. Governance forums are mapped under six arms, including Strategic Development and Delivery, which encompasses the STB and the CMT Programme. While the governance map accessed during fieldwork did not reflect the most recent changes in programme structure, it did confirm established linkages to the CAG and onward to the CQGG.

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion



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

Prioritisation of Findings

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

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

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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.

Cymru High Acuity Response Unit

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust

Reasonable Assurance

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Fieldwork	September 2025 - January 2026
Executive Sign Off	18 February 2026
Audit Committee	2 March 2026
Executive Lead	Andy Swinburn, Executive Director of Paramedicine
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

Executive Summary

Purpose

A review of the effectiveness of the Cymru High Acuity Response Unit (CHARU) in delivering improvements to patient care.

Scope and Limitations

As defined in the agreed audit brief, the scope of this review focused on assessing the effectiveness of CHARU in improving patient care and outcomes. It did not include an evaluation of the utilisation or deployment levels of CHARU services across Wales.

Overview

CHARU was introduced in 2022, replacing the previous Rapid Response Vehicle (RRV) model. It was designed to provide a more clinically focused approach to respond to high-acuity calls, ensuring that paramedics with enhanced skills and equipment are dispatched to incidents where they can deliver the greatest clinical benefit. This represents a shift from an emphasis on time-based targets to a focus on patient outcomes. When the role was introduced, 51 of the previous 71 RRV Paramedics chose to apply for the CHARU posts, with the remainder transferring to the Emergency Ambulance (EA) roster. At the date of audit fieldwork, there were 124 CHARU Paramedics in post, with an effective model of delivery considered achievable with a total complement of 153 (including 12.5 FTE of Senior Paramedic contribution).

Our audit found that CHARU is demonstrating clear strengths. Recent reporting shows improved Return of Spontaneous Circulation (RoSC) outcomes, indicating a strong clinical impact, and performance data confirms that CHARU performs favourably compared to the former RRV model when responding to Red incidents, supporting its intended focus on higher-acuity care.

The training programme is well structured, equipping staff with enhanced clinical skills such as ketamine administration, advanced airway management and mechanical CPR, reinforced through scenario-based assessment. Operational oversight is provided by Duty Operational Managers, Senior Paramedics and the availability of 24/7 clinical on-call support. Paramedics interviewed described the role as more stimulating and professionally rewarding than the previous model.

Governance arrangements are well established, with the Steering Group meeting quorate and CHARU activity routinely monitored through the Monthly Integrated Quality & Performance Report (MIQPR), Integrated Medium-Term Plan (IMTP) and Operations Quarterly Update Reports.

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

- There is no central evidence available to support the completion of six-monthly training portfolios for CHARU Paramedics. Portfolios are paper-based and monitored locally, limiting assurance of consistent completion and oversight.
- Beyond targeted analyses, there has been no comprehensive benefits realisation review of the CHARU model against its original intended outcomes, echoing issues previously identified in our APP report and Senior Paramedic Role audit report (issued November 2023: Reasonable Assurance); and no structured mechanism to gather systematic feedback from operational staff and Emergency Ambulance crews to confirm benefits or learning.
- There is no CHARU Paramedic representation on the CHARU Steering Group, limiting direct frontline insight to inform decision-making. The planned merger with the Senior Paramedic Steering Group should ensure appropriate representation going forward.

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

For management information, we have highlighted that the *Scope of Practice* requires updating to fully reflect all applicable CHARU variations within the skill requirements of the General Paramedic (Band 6) role. At present, reference is limited to the use of Ketamine and does not include the Mechanical Compression Device (LUCAS). However, we acknowledge that these expectations are clearly set out within the CHARU role advertisement and the associated training provision. As this represents an opportunity for enhancement, it does not impact the overall opinion.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Objectives	Related Findings	Assurance
1	Roles and responsibilities for CHARU have been clearly defined and consistently adopted across Wales.	1,2	**Reasonable**
2	Appropriate arrangements are in place to ensure CHARU staff receive adequate training and supervision to support their role effectively.	1	**Reasonable**
3	Mechanisms are in place to ensure CHARU staff are effectively supporting and enhancing patient care, including their contribution to the development and performance of their designated clinical teams.	2,3	**Reasonable**
4	Robust governance arrangements are in place to monitor the performance and effectiveness of CHARU, including how the service aligns with and supports the Trust's strategic objectives.	2,3	**Reasonable**

Findings & Agreed Action Plan

Objective 1: Roles and responsibilities for CHARU have been clearly defined and consistently adopted across Wales.	**Reasonable**

A risk workshop held in 2021 identified concerns regarding the ability to meet hourly staffing requirements for the Rapid Response Vehicle (RRV) model. Subsequent analysis confirmed the issue, which was escalated to senior leadership.

Although no formal business case was submitted, a presentation outlining the proposed CHARU model presented to the Strategic Transformation Board in June 2021, set out the anticipated benefits, workforce implications, and an implementation plan. A paper presented to the EMS Demand and Capacity Review in January 2022 indicated the CHARU model could deliver over 2,500 additional hours compared to the RRV model. Further options for remodelling and addressing staffing gaps were later presented to the Senior Leadership Team and Executive Leadership Team.

All 71 permanent RRV paramedics were informed of the transition to CHARU via individual letters and an intranet bulletin. These communications detailed transition arrangements, training requirements for new medicines and equipment (e.g. mechanical compression devices), and expectations regarding clinical and supervisory responsibilities. All were advised that if they did not wish to transfer to the CHARU resource, they had the option to revert to an emergency ambulance (EA) roster.

The intention behind development of the CHARU role was to support clinicians with the relevant skills and aptitude to further develop their practice in managing higher acuity patients, while maintaining their Paramedic role. As such, there is no CHARU specific job description – rather, that for a General Paramedic (Band 6) is applied, with reference to the 'Scope of Practice' (SoP) which sets out the variations in the skill requirements for roles within this banding. Review of the SoP noted that only use of Ketamine has been defined for the CHARU role and excludes reference to the use of Mechanical Compression device (LUCAS). Given that this expectation is clearly outlined in the CHARU role advertisement and supporting training (see Objective 2), no recommendation has been made; the issue is instead highlighted for management attention.

In order to assess the roles and responsibilities of the CHARU role, interviews were held with a CHARU Paramedic from each health board area. Conclusions drawn were that overall, the role met expectations, but some issues were noted:

- The furtherance of clinical skills (refer to *Objective 2* and **Key Finding 1**).
- Call allocation processes are inconsistent with expectations, e.g., calls downgraded from Purple/Red to Orange (previously Amber) still require attendance because they were initially allocated as high priority.
- Impact of geographical postings limits the number and type of calls that can be attended, particularly in rural areas.

Noting the lack of benefits realisation undertaken since the introduction of CHARU (refer to *Objective 3* and **Key Finding 2**) such feedback has not yet been formally considered by the Trust.

Objective 2: Appropriate arrangements are in place to ensure CHARU staff receive adequate training and supervision to support their role effectively.	**Reasonable**

The Trusts' RISC (Resuscitation in Special Circumstances) Faculty is made up of Health Board Clinical Leads and Senior Paramedics. It oversees CHARU recruitment, operational support provided to CHARU across Wales, and delivery of the CHARU training programme. This is delivered over three days with coverage including:

- Ketamine: Coverage on the use of this restricted pain relief medicine, which is limited to CHARU and Senior Paramedics (SPs), with emphasis on strict protocols around administration and permissions.
- Advanced airway management: Focussing on rapid assessment, maintaining airway patency, and applying structured algorithms to ensure effective oxygenation and ventilation while minimising delays and complications.
- CPR (Cardiopulmonary Resuscitation) / Mechanical CPR (LUCAS): Training to support the identification of patients who may benefit from resuscitation and those where cessation is appropriate, understanding the critical care needs of a ROSC (return of spontaneous circulation) patients, and the correct and safe use of the LUCAS device.
- RiSC: Integration of themes such as critical thinking, civility, legal and ethical awareness, human factors, professionalism, and a patient-centred care. This supports the development of non-technical skills essential for effective RISC practice, consolidates learning from the wider programme, and enhances practical application.
- Crew Resource Management (CRM): Principles to support effective team coordination during critical incidents. Although CHARU staff do not hold formal leadership roles, CRM supports collaborative incident management.

The programme concludes with two scenario-based assessments and a summative examination.

Post successful completion of the training programme and embarking on the operational role, CHARU paramedics must undergo a six-monthly consolidation and assessment phase with their Duty Operational Manager (DOM) and SPs. As part of this process, they are required to complete a portfolio identifying areas of good practice and areas for improvement, supporting personal development and alignment with HCPC (The Health and Care Professions Council) standards of conduct, performance and ethics. We note that the current requirement for the portfolio is paper-based and monitored at a local level, with no requirement to formally submit to the RISC Faculty, therefore limiting the assurance that such are completed in line with expectations (see **Key Finding 1**). Interviews with CHARU Paramedics indicated opportunities to further develop clinical skills within the role; the associated development needs of such could be addressed through a review of existing portfolios.

In relation to Statutory and Mandatory training, compliance was 85% for the 124 CHARU Paramedics in post at the time of fieldwork (data as at 16 December 2025). However, 33 CHARU Paramedics (27%) had not attended a MIST Day within the year. Our recent Mandatory In-Service Training report (issued December 2025: reasonable assurance) highlighted weaknesses in accountability structures for reporting and addressing individual non-compliance, with no formal arrangements for managing persistent issues. Recognising this is currently being monitored through the Trust's internal audit recommendation tracker, we have not sought to replicate the recommendation in this report.

Direct line management for CHARU Paramedics is undertaken by the DOMs, including the required administrative supervision (i.e. annual leave, PADR, training). Clinical supervision is primarily provided by the SPs, who also complete as a minimum one ride-outs (the expectation is two per annum, but as included in our Senior Paramedic Role report (issued November 2023) the second is not routinely being undertaken) and observational assessments. We were also advised that the Health Board Clinical Leads are regularly available and there is a 24/7 clinical on-call service providing additional support.

<table>
<tr><th colspan="2">Key Findings</th><th>Risk & Impact</th><th>Agreed Management Action</th></tr>
<tr><td rowspan="4">1</td><td rowspan="3">Training Portfolios

In line with the CHARU training programme, CHARU Paramedics are required to complete six-monthly reviews outlining good practice and areas for improvement. These reviews are monitored locally and are not formally submitted to the RiSC Faculty, resulting in no central assurance that they are being completed consistently or in accordance with expectation.

We understand that transitionary arrangements are in progress to transfer the portfolio onto Learn365 to enable central oversight by the RiSC Faculty.

Further, interviews with CHARU Paramedics identified a desire for furtherance of clinical skills within the role; expected coverage of such which could be identified through review of portfolios.</td><td rowspan="2">Inadequate oversight of CHARU Paramedics’ ongoing competency for high-risk interventions.</td><td>Agreed Action:
Complete the transition to Learn365 to facilitate a central assurance process to confirm that 6-monthly reviews are completed consistently and in accordance with the programme standards.
Review compliance data on a quarterly basis reporting to the newly established joint SP and CHARU steering group to provide assurance and escalation, where applicable.
Development of CHARU-specific Continuing Professional Development (CPD) sessions to facilitate additional training as appropriate.</td></tr>
<tr><td>Expected Evidence of Implementation:
Review module on Learn365 confirming routine upload of portfolios.
Central monitoring reports which have been reported to the joint SP and CHARU Steering Group.
CPD sessions and timetable.</td></tr>
<tr><td>Medium Priority</td><td rowspan="2">Officer: Greg Lloyd, Assistant Director of Clinical Delivery

Target Implementation Date: 30 September 2026</td></tr>
<tr><td>Theme: Training & Development</td><td>Control Operation</td></tr>
</table>

Objective 3: Mechanisms are in place to ensure CHARU staff are effectively supporting and enhancing patient care, including their contribution to the development and performance of their designated clinical teams.	**Reasonable**

The proposed benefits of CHARU were presented as follows:

To deliver high quality clinical care to the highest acuity patients	Platform to provide infrequent and bespoke interventions if required
Improve Return of Spontaneous Circulation (ROSC) rates in Wales	Offer some marginal resilience to red performance
Provide enhanced analgesia to patients with significant trauma	Ensure a more reliable and consistent provision of extended skills
Provide clinical leadership at the scene of such incidents by clinicians who have the necessary knowledge and skills	Utilise mechanical chest compression device when necessary following recommendations set out in the European and UK Resuscitation Guidelines (2021)

No formal measurement of the effectiveness of the role, and achievement of all intended benefits, has been undertaken. (**see Key Finding 2**). However, we were advised of only two areas where outcomes have been assessed which can reasonably be attributed to this cohort:

- ROSC rates: When the RRV model was remodelled into the CHARU model, Trust-wide ROSC rates for 2019/20 averaged 13.8%, the lowest in the UK at that time. The most recent data shows an average RoSC rate of 26% between October 2024 and June 2025. A further reported increase to 81% between July and October 2025 was attributed to changes in dispatch criteria (refer to *objective 1*)
- Ketamine: A clinical audit (October 2025) reviewed electronic Patient Clinical Records (ePCRs) involving Ketamine administration, examining the presence of documented pain scores and evidence at least one point reduction after administration. This audit will have encompassed ketamine use by CHARU Paramedics, SPs operating in CHARU capacity, and Advanced Paramedic Practitioners.

In addition, were provided with data showing that between September 2002 and October 2025, CHARU Paramedics accounted for an average of 70% of the vehicle types arriving first on scene.

We also acknowledge the work of the CHARU Steering Group (CSG) including its focus on utilisation, performance, workforce considerations and job-cycle reviews, all of which contribute to the ongoing monitoring and oversight of the CHARU role (see *objective 4* for further details).

Interviews with CHARU Paramedics indicated that their primary contribution to enhanced patient care relate to ketamine administration for pain relief, and increased exposure to airway and cardiac arrest cases, enabling experience with higher-acuity incidents. However, they highlighted:

- disparities in call profiles between rural and urban areas, largely due to socio-economic factors, limiting the consistency of opportunities to use CHARU-specific skills.
- concerns regarding potential skill fade where exposure is lower; and
- the need for improved clinical oversight within Clinical Contact Centres to ensure appropriate call allocation.

Given that utilisation and deployment of CHARU Paramedics were outside the scope of this review, no further analysis of these concerns was undertaken. CHARU staff generally felt they support Emergency Ambulance crews and suggested introducing mechanisms to obtain feedback to help assess impact (see **Key Finding 3**).

<table>
<tr><th colspan="2">Key Findings</th><th>Risk & Impact</th><th>Agreed Management Action</th></tr>
<tr><td rowspan="4">2</td><td rowspan="3">Evaluation and Lessons Learned

Although some data analysis has been undertaken across the CHARU role since its inception, there has been no comprehensive review or formal reporting to evaluate the role’s overall impact, comparative performance, or benefits realisation.

There is no evidence to determine if the Trust has proactively sought structured feedback from operational staff regarding the effectiveness, support, and integration of the CHARU model within frontline services.

In the absence of a structured assessment, lessons learnt and opportunities for optimisation may not be identified, and the Trust is unable to provide assurance that the role is delivering its intended operational and clinical benefits.

Noting the role supports the Emergency Ambulance crews, feedback from the same could be considered as route through which to assess the impact/effectiveness of the CHARU role as well.</td><td rowspan="2">Potential issues in deployment, resource utilisation, or clinical support may go unidentified, leading to inefficiencies.</td><td>Agreed Action:
Completion of a structured evaluation of the CHARU role to assess overall impact, comparative performance and benefits realisation
Evaluation to include quantitative service data with structured qualitative feedback from EA crews and other stakeholders.
Evaluation reported through the joint SP and CHARU Steering Group and into Senior Operations Team (SOT) as a AAA update.</td></tr>
<tr><td>Expected Evidence of Implementation:
Evaluation report.
Papers / minutes of evaluation report being taken to the joint SP and CHARU Steering Group; AAA reports from SOT.</td></tr>
<tr><td>Medium Priority</td><td rowspan="2">Officer: Greg Lloyd, Assistant Director of Clinical Delivery

Target Implementation Date: 30 June 2026</td></tr>
<tr><td>Theme: Lessons Learnt</td><td>Control Design</td></tr>
</table>

Objective 4: Robust governance arrangements are in place to monitor the performance and effectiveness of CHARU, including how the service aligns with and supports the Trust's strategic objectives.	**Reasonable**

The CHARU Steering Group (CSG) was established prior to the introduction of the CHARU role in early 2022. The group typically meets monthly and considers recruitment and workforce planning, training and development, utilisation and operational performance, and job cycle reviews. The Terms of Reference (ToR) were updated in April 2025 and approved by the Senior Operations Team (SOT). Quoracy is defined as the Chair plus four members, and attendance records show that at all meetings reviewed (January to October 2025) were quorate.

Review of the CSG membership indicates that CHARU Paramedics are not currently represented (see **Key Finding 3**). This gap was also raised during interviews, where staff noted the absence of a mechanism to provide insight into the day-to-day operational challenges faced on the ground.

The ToR state meetings should take place "monthly or as otherwise directed by the Chair." While meetings have been less frequent during the year (not held February, March, June or July 2025), discussions with the Assistant Director of Clinical Delivery confirmed that as the role has become embedded within business-as-usual processes, the need for monthly meetings has reduced. We understand that during 2026, the CSG will merge with the Senior Paramedic Steering Group (SPSG) to provide a more aligned governance structure across both roles. As the SPSG includes SP representation, consideration will be needed to ensure consistent representation for CHARU Paramedics (see **Key Finding 3**).

As defined in the ToR, an AAA (Assure, Advise, Alert) report of each CSG meeting should be submitted to SOT, which in turn reports into the Executive Leadership Team (ELT). Our review of SOT AAA reports found no onward escalations relating to the CSG during the year.

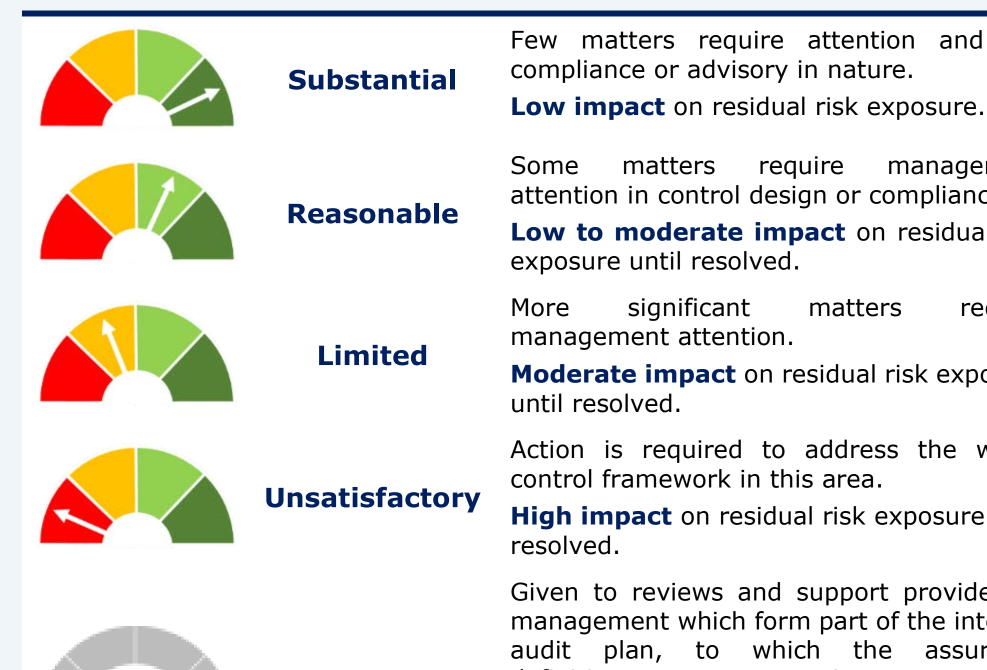
The Trust's Monthly Integrated Quality & Performance Report (MIQPR) provides a detailed analysis by vehicle type, including pan-Wales utilisation, average job cycle, and average jobs per shift. The reports note that CHARU performance, in supporting Red incidents, compares favourably with the previous Rapid Response Vehicle (RRV) model. CHARU Unit Hours Production (UHP) is also routinely reported and monitored against the full roll-out requirement outlined within the Integrated Medium-Term Plan (IMTP), although we note this requirement has not yet been fully achieved. Both the MIQPR and the IMTP are presented to the Trust Board and all relevant sub-committees at each meeting. Additional CHARU updates are also included within the Operations Quarterly Update Report presented to Board sub-committees.

In addition, a high-level update was presented to the Finance and Performance Committee by the Executive Director of Operations in September 2024. This report outlined key metrics, including contribution to red calls, response by priority, incident arrival order, and utilisation. It emphasised that ambulance resource utilisation, including CHARU, is an output metric reflecting deployment during service delivery, rather than a performance measure of effectiveness or efficiency. We note that a formal benefits realisation exercise against the original objectives of the CHARU role has not been undertaken (see **Key Finding 2**). The same was applicable within our audit report of the Senior Paramedic role (issued November 2023: reasonable assurance). Our consideration of the intended benefits, against available evidence notes some benefits have been achieved however, a broader clinical and operational evaluation would provide stronger assurance regarding the effectiveness of the role.

	Key Findings	Risk & Impact	Agreed Management Action
3	**CHARU Steering Group Membership** Review of the ToR, supported by interviews with CHARU Paramedics during fieldwork, identified that the CSG does not include operational CHARU Paramedic representation. This limits the group's ability to receive direct, current insight into the day-to-day challenges faced by the service. Without operational CHARU input, the Steering Group may make decisions based on incomplete or inaccurate understanding of frontline realities. This increases the risk of delays in addressing operational issues, reduced effectiveness of the CHARU model, diminished staff engagement, and potential negative effects on resource utilisation, service performance, and ultimately the quality and consistency of patient care. We understand there is a planned merger of the CSG with the SPSG. As the latter includes SP representation, membership requirements should be reviewed to ensure appropriate and consistent representation is maintained.	The absence of CHARU representation increases the risk of ineffective governance, misaligned priorities, and reduced ability to identify emerging operational issues.	**Agreed Action:** • As part of the planned merger of the CSG and SPSG, review and update the terms of reference to ensure appropriate and consistent operational representation from the CHARU workforce. • Establish a mechanism for structured operational feedback ensuring emerging issues and service challenges are consistently escalated and discussed. **Expected Evidence of Implementation:** • Updated terms of reference. • Structured feedback mechanisms e.g., agenda sections / standing agenda items relating to operational oversight.
		Medium Priority	**Officer:** Greg Lloyd, Assistant Director of Clinical Delivery **Target Implementation Date:** 30 April 2026
	Theme: Governance	Control Design	

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion



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

Prioritisation of Findings

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

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

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

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

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

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.

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

Date issued: February 2026

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

Introduction

This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at the Welsh Ambulance Services University NHS Trust (The Trust). We presented our most recent Audit Plan to the committee in March 2025.

We also provide additional information on:

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

Accounts audit update

Independent Examination of the 2024-25 Charitable Funds' Financial Statements

- **Executive Lead:** Executive Director of Finance and Corporate Resources
- **Focus of the work:** To provide an independent examination of the Trust's 2024-25 Charity Annual Report and Accounts
- **Status:** Complete
- **Committee date:** Presented to Charity Committee 13 January 2026

Audit of the Trust's 2025-26 Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance and Corporate Resources
- **Focus of the work:** To provide an audit opinion on the Trust's 2025-26 Annual Report and Accounts.
- **Status:** Planning work ongoing
- **Expected committee date:** 23 June 2026

Performance audit update

Structured assessment 2025 – core

- **Executive Lead:** Board Secretary / Director of Corporate Governance
- **Focus of the work:** Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2025 Structured Assessment reviewed:
  - Board and committee cohesion and effectiveness;
  - Corporate systems of assurance;
  - Corporate planning arrangements; and
  - Corporate financial planning and management arrangements.
- **Status:** Complete.
- **Committee date:** December 2025

Structured assessment 2024 - deep dive review of investment in digital systems

- **Executive Lead:** Director of Digital
- **Focus of the work:** This work will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Drafting
- **Expected committee date:** April 2026

Review of Non-Emergency Patient Transport Service

- **Executive Lead:** Executive Director of Operations
- **Focus of the work:** This review will examine the effectiveness and efficiency of the Trust's Non-Emergency Patient Transport Service, with a particular focus on arrangements for the transfer and discharge function.
- **Status:** Fieldwork in progress
- **Expected committee date:** April 2026

Structured assessment 2025 - deep dive review of the arrangements to manage estates

- **Executive Lead:** Executive Director of Finance and Corporate Resources
- **Focus of the work:** This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Planning
- **Expected committee date:** September 2026

Other relevant publications

Over the past three months, the Auditor General has published other relevant outputs which have relevance to the NHS. These are set out below.

Publication	Date
Checking the patients. Results from a pilot data matching exercise on GP patient lists	January 2026
Positive action on fraud and error in community pharmacy but more analysis could reap rewards (news article)	December 2025
Biodiversity and Resilience of Ecosystems Duty Report for 2023-2025 and Plan for 2026-2028	December 2025
Facing the Future – Auditor General for Wales Podcast – Episode 4	November 2025
Opportunities for Change – Auditor General for Wales Podcast – Episode 3	November 2025
Under Pressure – Auditor General for Wales Podcast – Episode 2	November 2025
A Unique Perspective – Auditor General for Wales Podcast – Episode 1	November 2025

Since the last committee update, Audit Wales has also published the following corporate document.

Fee Scheme 2026-27	January 2026

There are no relevant Audit Wales consultations currently underway.

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

Visit our website to find:

Our publications which cover our audit work at public bodies.

Information on our upcoming work and forward work programme for performance audit.

Data tools to help you better understand public spending trends.

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

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Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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

Welsh Ambulance Services University NHS Trust – Annual Audit Summary 2025

Date issued: December 2025

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

Foreword

Adrian Crompton

Auditor General for Wales

I am pleased to share my Annual Audit Summary for the Welsh Ambulance Services University NHS Trust (the Trust). It summarises the main findings from my 2025 audit work undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004 and the Well-Being of Future Generations (Wales) Act 2015.

I provided opinions on whether the accounts were properly prepared and gave a true and fair view, in all material aspects, and whether expenditure and income have been used for the purposes intended and in accordance with the authorities which govern you.

My audit team has also assessed whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and acted in line with the sustainable development principle. In doing so, my audit team has undertaken my annual structured assessment work and reviewed urgent and emergency care services and digital transformation. As set out in my audit plan, these reviews have been carried out in line with the International Organisation of Supreme Audit Institutions (INTOSAI) standards.

At the time of publishing this summary, the Trust was subject to Level 1 under the Welsh Government's escalation and intervention arrangements].

The detailed audit findings for each of my reviews are set out in the respective reports which my audit team have presented to the Audit, Risk and Assurance Committee throughout the year. The performance audit reports are available on the Audit Wales website and further links are available in the summary.

The Annual Audit Summary should be shared with the Board. I will then make the summary available to the public on the Audit Wales website.

I would like to extend my gratitude to the Trust's staff for their help and cooperation throughout my audit.

Your audit at a glance

I received the draft accounts and annual report ahead of the agreed deadlines of 2 May and 9 May 2025 respectively. The quality of the draft accounts and working papers was good.

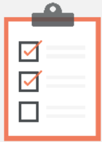
In advance of the agreed deadline of 30 June 2025 I issued an unqualified true and fair opinion, and an unqualified regularity opinion.

There were no uncorrected misstatements in the accounts.

There were no other significant issues to report.

My performance audit work found that the Board maintains effective governance and assurance, with well-run meetings and ongoing efforts to strengthen strategic risk oversight. The Trust consistently meets statutory financial duties and secures approval of its Integrated Medium Term Plan, while also setting wellbeing objectives during 2025. However, its capacity is stretched by major change programmes, highlighting the need for realistic and affordable plans. Despite efforts in urgent and emergency care, increased demand and ongoing delays continue to affect performance and patient outcomes.

My audit team made several recommendations to the Trust which focus on strengthening policy management, enhancing reporting to the Board and strengthening its information around alternative urgent and emergency care services.



There is still some work outstanding from my Audit Plan dated April 2025. My team expects to complete this work by March 2026.

Audit of accounts findings

Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides opinions on whether the accounts are properly prepared and give and true and fair view, in all material aspects, and the proper use ('regularity') of public monies.

My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

The draft accounts and annual report were presented for audit on 2 May and 9 May 2025 respectively. This was in line with the deadlines set by the Welsh Government. The quality of the draft accounts presented for audit was generally good.

My audit opinions

I must report issues arising from my work to those charged with governance for consideration before I issue my audit opinion on the accounts. I reported these issues within my Audit of Accounts Report to the Audit, Risk and Assurance Committee on 24 June 2025.

True and fair

A number of changes were made to the draft accounts arising from my audit work.

There were no uncorrected misstatements.

There were no other significant issues to report

My work did not identify any material weaknesses in internal controls (as relevant to my audit), and I made no recommendations.

I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them.

Regularity

The Trust is only allowed to receive income and incur expenditure in ways that follow the rules set by the authorities that govern it.

Further, where a Trust does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

The Trust met its first financial duty to break even over a three-year period ending 31 March 2025. All other material financial transactions were in accordance with authorities and used for the purposes intended, so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2024-25 accounts. The Trust met its second financial duty to have an approved three-year plan in place.

Whole of Government Accounts

I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Trust's financial position at 31 March 2025 and the return was prepared in accordance with the Treasury's instructions.

Performance audit findings

Structured assessment

My team looked at how well the Trust is governed and whether it makes the best use of its resources.

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

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

I made four recommendations focused on

- 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.

Managing urgent and emergency demand

My team looked at how well the Trust is managing demand for urgent and emergency care to reduce unnecessary pressure on the system.

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

I made two recommendations focused on:

- Addressing outdated information on the 111 Wales website
- Working with health boards to maintain up-to-date information on its directories of service.

Performance audit work still underway

At the time of reporting, the following reviews from the 2025 Audit Plan were still underway at the Trust:

- digital transformation;
- estates management.
- Non Emergency Patient Transport Services.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use three lines of assurance to show how we achieve this. We have set up an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.

Our People

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

Visit our website to find:

Our publications which cover our audit work at public bodies.

Information on our upcoming work and forward work programme for performance audit.

Data tools to help you better understand public spending trends.

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

Audit Wales

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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.

Welsh Ambulance Services University NHS Trust

Outline Audit Plan 2026

Audit Year: 2025-26
Date issued: February 2026

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions. Audit Wales is not a legal entity and itself does not have any functions.

No responsibility is taken by the Auditor General, the staff of the Wales Audit Office or, where applicable, the appointed auditor in relation to any member, director, officer or other employee in their individual capacity, or to any third party.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

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

Mae’r ddogfen hon hefyd ar gael yn Gymraeg.

About Audit Wales

Our aims:

the people of Wales that public money is well managed

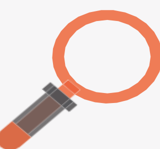
Explain

how public money is being used to meet people's needs

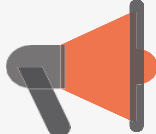
Inspire

and empower the Welsh public sector to improve

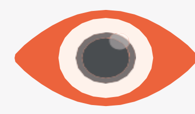
Our ambitions:



Fully exploit our unique perspective, expertise and depth of insight



Strengthen our position as an authoritative, trusted and independent voice



Increase our visibility, influence and relevance

Be a model organisation for the public sector in Wales and beyond

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Fees and audit team 7

Audit timeline 9

Audit quality 10

Introduction

This Outline Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice. It also sets out details of my audit team and key dates for delivering my audit team's activities and planned outputs. I intend to share a Detailed Audit Plan later in the year following the completion of my planning work. It will set out my estimated audit fee and the work my team intends to undertake to address the audit risks identified and other key areas of audit focus during 2026.

My audit responsibilities

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure, and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to you in my Detailed Audit Plan.

I am also required to certify a return to the Welsh Government which provides information about the Trust to support preparation of the Whole of Government Accounts.

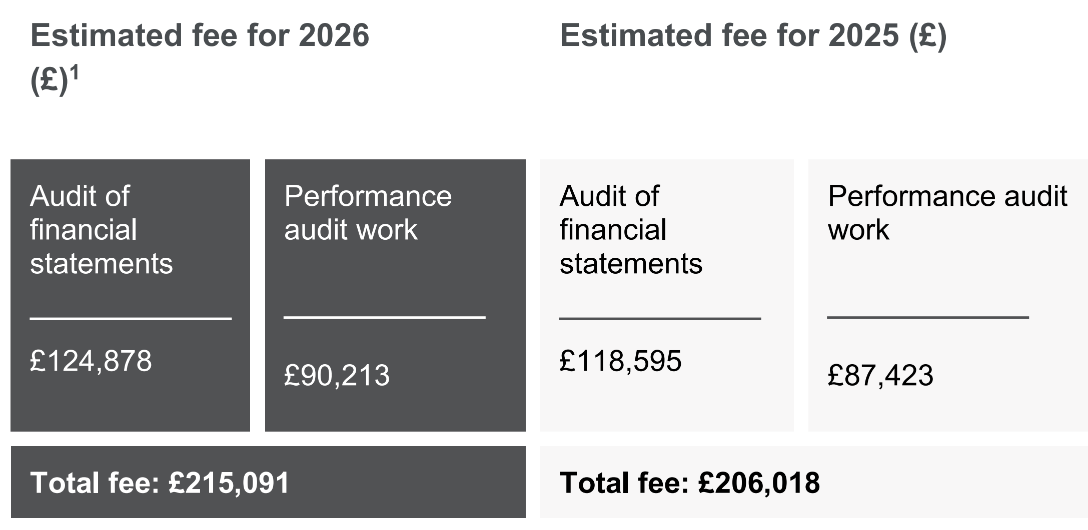
Performance audit work

I must satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Trust and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

Fees and audit team

In January 2026 we published our 2026-27 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 5.3%. The estimated total audit fee for 2026 is £215,091 (2025: £206,018). The following table sets out a further breakdown of your estimated audit fee.



Estimated fee for 2026 (£)[1]		Estimated fee for 2025 (£)	
Audit of financial statements	Performance audit work	Audit of financial statements	Performance audit work
£124,878	£90,213	£118,595	£87,423
Total fee: £215,091		**Total fee: £206,018**	

I will provide an updated fee in my Detailed Audit Plan in April 2026, following completion of my detailed risk assessment.

[1] Please note the fee shown is still subject to internal moderation within Audit Wales. The fees shown in this document are exclusive of VAT.

Your engagement team:

Dave Thomas	Engagement Director & Audit Director (Performance Audit)
Gareth Lucey	Audit Director (Financial Audit)
Yvonne Thomas	Audit Manager (Financial Audit)
Darren Griffiths	Audit Manager (Performance Audit)
Sioned Owen	Audit Lead (Financial Audit)
Fflur Jones	Audit Lead (Performance Audit)

We confirm that our audit team members are all independent of the Trust and your officers.

Audit timeline

We set out below key dates for delivery of our audit work and planned outputs.

Planned output	Work undertaken	Report finalised
2026 Outline Audit Plan	January - February 2026	February 2026
2026 Detailed Audit Plan	March - April 2026	April 2026
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements.	May - June 2026	June 2026
Performance audit work: • Structured Assessment, • In terms of local project work, I plan to undertake a review of the Trust's management of the 111 service. My team will engage with the Trust in the scoping and design of this work. It is possible that as I conclude my planning work, additional areas for review may be identified. I will confirm the exact focus of my local project work in my detailed Audit Plan in April 2026.	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study, however, our overall aim will be to substantially complete the work set out in this plan by the end of March 2027.	

Audit quality

My commitment to audit quality in Audit Wales is absolute.

I believe that audit quality is about getting things right first-time.

We use a three lines of assurance model to demonstrate how we achieve this.

We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD[2] and our Chair acts as a link to our Board on audit quality. For more information see our Audit Quality Annual Report.

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Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

[2] QAD is the Quality Assurance Department of ICAEW.

Archwilio Cymru
Audit Wales

Agenda Item No.	07

REPORT TITLE

ARAC 2025/26 Quality Governance Review

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	2 March 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. At the 2 December 2025 ARAC meeting members endorsed amendments to terms of reference for the Finance and Performance Committee (FPC), Quality, Patient Experience and Safety Committee (QUEST) and People and Culture Committee (PCC). These were approved by the board on 29 January 2026, along with the terms of reference for the Academic Partnerships Committee and Remuneration Committee. The Corporate Trustee approved the amended terms

of reference for the Charity Committee on the same day. ARAC's endorsement was not sought on the latter three given the extensive review in December of the proposed revised committee framework and the fact that Remuneration Committee and Charity Committee did not have changes to their terms of reference, and that that of APC had been reflected in the paper that went to ARAC on 2 December.

2. This meeting is therefore focused on the quality and governance review for ARAC.

ARAC Terms of Reference

1. This committee's terms of reference are attached at **Annex 1**. The purpose of the committee is to advise and assure the board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales

2. Changes to the terms of reference with respect to its potential for oversight of information governance, cyber and resilience, is pending the review of Good Governance Institute, as set out in the 2 December paper. Therefore, for the time being in any event, the changes marked up at Annex 1 are not material.

3. Members will see that there is a change from the Executive Director of Quality and Nursing as a prescribed member to that of the Deputy Director of Quality and Putting Things Right, Wendy Herbert.

National Audit Office (NAO) Toolkit

4. As has been the case for a number of years, the effectiveness of this committee is reviewed against the NAO toolkit. 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. This has been replicated for this year's review.

5. The ARAC sub-group (comprised of the Chair and Non-Executive Director (NED) members of ARAC, the Executive Director of Finance and Corporate Resources, and the Director of Corporate Governance/Board Secretary) met on 27 January 2026. The sub-group's assessment of this committee's position against the various essential and good practice criteria is attached at **Annex 2**.

6. Members are invited to consider the attached self-assessment against the essential and good practice areas in the toolkit completed by the sub-group. The sub-group has highlighted below some elements for wider discussion, as this was considered appropriate given recent discussions in committee and at Board, and following the review of the framework undertaken this year. Members are asked to indicate if they disagree with the position set out by the sub-group, or if they wish to propose a focus on areas other than those drawn out below:

   6.1 Question 1.2.9 indicates that it is good practice for the ARAC Chair and other members to keep in touch on a continuing basis between meetings.

      (a) ARAC members remain connected through touchpoint meetings during the year, and NED meetings allow the ARAC Chair to raise any issues with NED colleagues. Regular meetings of the ARAC sub-group take place with the recent focus being the review of the board's committee framework. The ARAC Chair and the Executive Director of Finance and Corporate Resources also meet regularly on a one to one basis, and both attend agenda setting meetings. The Chair also meets with the auditors regularly.

      (b) The sub-group will continue to meet quarterly with the Chair feeding back to the committee on issues discussed. It is likely that the outputs of the Good Governance Institute will be the focus of those discussions. Members are invited to indicate whether they agree with this approach.

   6.2 Section 2 relates to skills and experience.

      (a) Sub-group members note that committee members are appointed for their experience and skills, particularly executive and senior leaders whose portfolios align with a committee's remit. Where a committee does not have specific expertise in an area, members are encouraged to seek bespoke development, either through the Board development programme or through deep dive sessions. This is particularly important in areas identified in the toolkit such as cyber, digital, environmental and sustainability, commercial and procurement. The sub-group proposes that this issue is raised at board to ensure that, pending the broader review of the skills mix referred to at section (b) below, chairs of all board committees (including ARAC) continue to encourage targeted upskilling where it is needed. This will help maintain robust oversight and understanding, while avoiding the risk of committees becoming overly operational. Members are invited to indicate whether they agree that ARAC should take this forward.

      (b) The sub-group recognised that there may be work for ARAC to undertake at board level to review the board skills matrix, to ensure it is fit for purpose and that the distribution of NEDs and Directors across committees aligns with remit and the matrix. Members are asked whether they agree that this is an appropriate area for ARAC to lead on, and whether they support ARAC taking this work forward.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section
The Committee is requested to: 1. Endorse changes to its terms of reference 2. Discuss the committee' effectiveness and NAO responses, in particular those drawn out at paragraph 5

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 ARAC terms of reference **Annex 2** NAO toolkit responses from sub-group

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
N/A

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document here for further details.	
Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
27 January 2026	ARAC Sub-Group discussions on NAO toolkit

AUDIT, RISK AND ASSURANCE COMMITTEE

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

1. INTRODUCTION

1.2 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 **Audit, Risk and Assurance 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 board 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.

2. INTRODUCTION

2.2 The purpose of the committee is to advise and assure the board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.3 Where appropriate, the committee will advise the board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.4 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.

2.5 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.

2.6 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 RESPONSIBILITIES

3.1 With regard to its role in providing advice to the board, the committee will comment specifically upon:

(a) the adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance process, including the Annual Governance Statement, providing reasonable assurance on:

(i) the organisation's ability to achieve its objectives.

(ii) compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others.

(iii) the efficiency, effectiveness, and economic use of resources; and

(iv) the extent to which the organisation safeguards and protects all its assets, including its people,

and to ensure the provision of high quality, safe healthcare for its citizens:

(b) the board's Standing Orders and Standing Financial Instructions (including associated framework documents, as appropriate) and receive a report from the Director of Corporate Governance/Board Secretary on any non-compliance.

(c) the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements'

letter of representation to the external auditors; the committee shall approve all financial procedures.

(d) the Schedule of Losses and Special Payments.

(e) the register of Single Tender Actions.

(f) the planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports).

(g) the adequacy of executive and management's response to issues identified by audit, inspection, and other assurance activity.

(h) proposals for accessing Internal Audit services via Shared Services arrangements (where appropriate).

(i) anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

(j) any particular matter or issue upon which the board or the Accountable Officer may seek advice.

(k) the adequacy of the arrangements for Declarations of Interests, providing an annual report to the board to this effect.

(l) arrangements for the discharge of the Trust's responsibility as bailee for patients' property.

3.2 The committee will support the board with regard to its responsibilities for governance (including risk and control) by reviewing:

(a) all risk and control related disclosure statements (in particular the Annual Governance Statement) together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the board.

(b) the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

(c) the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements.

(d) the policies and procedures for all work related to fraud and corruption as

set out in the Welsh Government Directions and as required by the Counter Fraud and Security Management Service.

3.3 In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit, and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness. The committee will receive assurance on the integration and effectiveness of governance structures that span the entirety of the organisation from floor to board.

3.4 This will be evidenced through the committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the committee to review and form an opinion on:

(a) the comprehensiveness of assurances in meeting the board and the Accountable Officers assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

(b) the reliability and integrity of these assurances.

3.5 To achieve this, the committee's programme of work will 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) monitor progress against the requirement of the Auditors' Management Letter.

(i) receive and review key Trust Annual Reports e.g., Trust Annual Report (including the Annual Governance Statement) and make recommendations to the board for their adoption.

(j) review the content of the Corporate Risk Register and obtain assurance that control measures are in place to mitigate all identified risks.

Risks and Audit

3.6 The committee has overall responsibility for ensuring that corporate risks are identified and are being properly managed within the Trust and that there are processes in place to address and take forward audit recommendations. Nevertheless, each risk from the corporate risk register and Board Assurance

Framework and each recommendation from the audit tracker, will be presented to an appropriate board committee who will be responsible for ensuring that the Trust is managing and progressing each item as planned. In addition, these committees will follow due process to escalate any issues to Audit, Risk and Assurance Committee for oversight, scrutiny and assurance. Regular reports will be provided to individual committees on those items for which they have responsibility for oversight and overall Trust-wide progress reports will be presented to each Audit, Risk and Assurance Committee.

3.7 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 DELEGATED RESPONSIBILITIES

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 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 board's procurement, budgetary and other requirements

4.3 The committee is authorised to approve Trust wide policies 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.

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.

Access

4.7 The Head of Internal Audit and the Engagement Leads/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the committee.

4.8 The committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

4.9 The Chair of committee shall have reasonable access to Directors and other relevant senior staff.

Sub Committees

4.10 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 Finance and Corporate Resources (Committee Lead)
- Director of People
- ~~Executive Director of Quality and Nursing~~Deputy Director of Quality and Putting Things Right
- Assistant Director of Operations, National Operations & Support
- Director of Corporate Governance/Board Secretary
- Assistant Director of Corporate Governance and Risk
- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General
- Trade Union Partners (x2)
- Other Directors will attend as required by the committee Chair

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

5.6 The Chair of the Trust Board shall not be a member of the committee but may be invited to attend meetings.

5.7 The Chief Executive (Accountable Officer) will be invited to attend meetings of the committee and will attend to discuss the process for assurance that supports the Annual Governance Statement.

5.8 The committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter.

5.9 The committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and expertise e.g. Wales Audit Office, Internal Audit

5.10 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 they are unable to attend and the name of the member who will attend as the substitute.

Quorum

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

5.12 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

5.13 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.

5.14 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.

5.15 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 no less than quarterly and otherwise as the Chair of the committee deems necessary, consistent with the Trust's annual plan of board business and calendar of meetings. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

6.3 The Chair of committee, External Auditor or Head of Internal Audit may request a private meeting if they consider that one is necessary.

Withdrawal of individuals in attendance

6.4 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 particular matters.

6.5 The committee may meet in private – without the presence of management – where necessary.

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

7.1 Although the board has delegated authority to the committee for the exercise of certain functions as set out within these terms of reference, the board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2 The committee is directly accountable to the board for its performance in exercising the functions set out in these terms of reference.

7.3 The committee, through its Chair and members, shall work closely with the board's other committees, including where appropriate joint (sub) 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 information;

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

7.4 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.

7.5 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 committee shall provide a written, Annual Report to the board and the Chief Executive (Accountable Officer) on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

8.3 The board may also require the committee Chair to report upon the committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

8.4 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. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

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

Role of Committee	Reference	NAO Question	Response for 2025-26 Quality and Governance Review
1. Membership, Independence, Objectivity and Understanding			
Membership, Independence and Objectivity			
Essentials	**1.1.1**	The chair is a non-executive Board member and possesses an appropriate level of relevant experience.	The Chair is a Non-Executive Director (NED) and qualified Accountant
	1.1.2	In terms of numbers, membership of the ARAC is sufficient to discharge its responsibilities.	ARAC membership include three NEDs and prescribed attendees relevant to the audit, risk and assurance remit. This include the Executive Director of Finance and Corporate Resources (lead executive), Director of Corporate Governance/Board Secretary, Deputy Director of Quality, Director of People and the Assistant Director of Corporate Governance and Risk.
	1.1.3	The ARAC explores the option of bringing in additional independent, non-executive members from sources other than the Board to ensure an appropriate level of skills and experience.	Independent advisors or specialists can be invited to meetings as required. The board skills mix document is updated regularly to ensure we have the right spread of membership across committees and ARAC. Expertise is brought in during development for board or committees.
	1.1.4	The accounting officer and the finance director routinely attend meetings.	The Executive Director of Finance and Corporate Services is the lead executive and attends each meeting. The CEO is invited to each meeting and attended 2 meetings in 2025/26, including that at which the audited financial accounts and annual report was presented.
	1.1.5	The head of internal audit, head of risk, and external audit routinely attend meetings.	Confirmed
	1.1.6	ARAC members understand their responsibilities regarding identifying, declaring and resolving conflicts of interest.	ARAC approves the Standards of Business Conduct Policy. The board register of interests is included in each ARAC meeting. Board members are required to update their declarations of interest when they change, and annually to confirm them as part of the eligibility review that goes to RemCom. Members have not been called upon in 2025/26 to resolve any conflicts of interest. The Director of Corporate Governance/Board Secretary advises the board and ARAC on matters related to declarations of interest. Discussions in the sub-group in 2025/26 regarding managing conflicts with ARAC members when they are members of other committees. This will be covered in changes to ToR regarding roles and responsibilities post-GGI work.
	1.1.7	ARAC members have a clear understanding of what is expected of them in their role, and this was set out clearly at the time of appointment.	A committee specific induction programme was agreed with ARAC in 2024/25 and is now in place for all committees. Additionally, Audit Wales conducted an session in December 2025 on the work of Audit Wales and the role of ARAC members.
	1.1.8	The ARAC has access to sufficient funding to cover the costs incurred in fulfilling its role.	Confirmed.
Good Practice	**1.1.9**	All members and attendees make valuable contributions to meetings.	This issue was discussed with members on 6 March 2024 and it was suggested that members may wish to use Ibabs for pre-meeting comments to enhance engagement. This has not been done to date but remains an option. Each meeting includes a reflections section and contributions or limitations on contributions could be taken at this time also. The sub-group felt that the Chair continues to allow sufficient time for all members and attendees to raise issues and there is good engagement and discussion at meetings
	1.1.10	If any conflicts of interest are identified, the ARAC Chair is effective in ensuring the associated risks are effectively managed and continually monitored.	These have not arisen in 2025/26 however see the response to 1.1.6 above
Making the most of your time			
Essentials	**1.2.1**	The ARAC meets at least four times during the year.	Confirmed for 2024/25.
	1.2.2	The number of meetings held are sufficient to allow the ARAC to perform as effectively as possible.	Confirmed, as evidenced by the cycle of business monitoring report and committee annual report to board.
	1.2.3	Meetings are well-aligned with the audit and assurance cycle	The annual audit plans for internal audit and external audit are agreed ahead of each new financial year and the annual audit of financial accounts and review of the annual report is cycled appropriately and in line with the Welsh Government Manual for Accounts

Good Practice	**1.2.4**	The ARAC receives information and papers far enough in advance for them to fully consider before the meeting	Papers for ARAC are published by noon seven days prior to the meeting. These are on Ibabs for members and on the Trust website for the public. This is in line with our Standing Orders. Any late papers are only uploaded following agreement from the Chair. In 2025 as a result of the Audit Wales Structured Assessment, any papers uploaded to the board or a board committee outside these timeframes will be reported to ARAC as a breach of standing orders.
	1.2.5	All matters falling within the terms of reference of the ARAC are covered adequately over the course of the year or a reasonable time period.	Confirmed, as evidenced by the cycle of business monitoring report and committee annual report to board.
	1.2.6	Meetings of the ARAC are long enough to ensure that all agenda items are covered in sufficient detail.	This was discussed on 6 March 2024 and it was felt that The Committee while the current length was generally sufficient, it was important to ensure meetings do not become too long, which could impact the quality of discussion. There was a suggestion to consider splitting longer meetings over two mornings if necessary. This has not taken place. Confirmed, as evidenced by the cycle of business monitoring report and committee annual report to board.
	1.2.7	Deep dives are undertaken in key and emerging risk areas, and these are sufficiently detailed so the ARAC can understand the risk and challenge management.	ARAC has the monitoring of the risk management process and systems in its remit as opposed currently to individual risks to monitor. It must be assured that operationally we have a sound system of risk management and that board committees are scrutinising and monitoring appropriately. They do this by way of monitoring the risk transformation programme, by the Structured Assessment, and by the annual Internal Audit Risk Management Internal Audit and the Head of Internal Audit Opinion. The need for a deep dive on principal risks is explored at each agenda setting meeting with committee chairs and leads. Where there are areas within the remit of ARAC for a deep dive that is done from time to time (for example, lessons learned from deep dives into losses and special payments)
	1.2.8	There is sufficient time between ARAC meetings and main board meetings to allow any work arising from the meeting to be undertaken and reported to the Board as appropriate.	Use of Microsoft Co-pilot enables the AAA report from ARAC to board is completed within 48 hours and distributed to the board soon afterwards. It is also published at this time on the Trust's website for the public's view. Where possible, meetings are scheduled to compliment the cadence of board meetings.
	1.2.9	The ARAC Chair – and other members where relevant – keep in touch with other key attendees on a continuing basis between meetings.	ARAC members have an opportunity to keep in touch with members via other touchpoint meetings throughout the year. The NED meetings are also an opportunity for the ARAC chair to raise any issues with NED colleagues. Regular meetings between the NEDs, the Executive Director of Finance and Corporate Resource and the Director of Corporate Governance/Board Secretary started in 2024/25 to review ARAC's effectiveness via this questionnaire on a continuous basis. However during 2025/26 these meetings have focused primarily on the 2025/26 review of the board's committee framework. The ARAC Chair and the Executive Director of Finance and Corporate Resources have regular 1:1s and agenda setting meetings are attended by both.
	1.2.10	The ARAC meets in private - without the presence of management - when necessary and this time is used effectively.	The TOR was amended in 2025/26 to reflect this requirement, however there has not been a need this year for the Chair to formally convene a meeting without the presence of management.
	1.2.11	The ARAC is provided with sufficient administrative and secretarial support to undertake its duties to the required standard.	Confirmed. The Corporate Governance Team service ARAC.
	1.2.12	The ARAC is clear on the type of skills and experience should be sought in a new member – and the chair is involved in the appointment process.	The appointment of NEDs to the board is led by Welsh Government, however WAST does take account of our skills mix on selection, and those skills are referred to by the ARAC chair on appointment of new members to ARAC
	1.2.13	Sufficient time is afforded to the different providers of assurance to the ARAC across the various lines of defence, notably risk management, internal audit and external audit.	Confirmed. The agenda always includes these three items as standard with sufficient time for discussion, scrutiny and assurance.
	1.2.14	The ARAC has a forward plan for its meetings so it can consider issues at the right time and in the right level of detail.	Confirmed. The cycle of business is in place and agreed by ARAC and is monitored at each meeting.
	1.2.15	The ARAC acts in an inclusive and respectful manner, avoids 'group think', and provides an appropriate balance between challenge and support.	The Chair allows sufficient time for all members and attendees to raise issues and there is good engagement and respectful discussion at meetings. Ratings on internal audit reports and recommendations have been challenged and scrutiny of progress against actions has been a particular focus.
2.Skills and experience			
Range of skills			
	2.1.1	The ARAC possesses a good range of skills and experience in relation to governance, risk and control.	The appointment of NEDs to the board is led by Welsh Government, however WAST does take account of our skills mix on selection, and those skills are referred to by the ARAC chair on appointment of new members to ARAC. Prescribed attendees are selected for their skills and experience including that of governance, risk and control. However, where ARAC membership doesn't have the specific skills, it ensures the areas are considered by the appropriate committee that has the skills and places reliance on those committees for scrutiny, and ARAC seeks assurance from them accordingly.

Essentials	**2.1.2**	At least one member of the ARAC has recent and relevant financial experience sufficient to allow them to analyse the financial statements and understand good financial management disciplines.	The Chair and the Executive Director of Finance and Corporate Resources are qualified Accountants
	2.1.3	The ARAC proactively identifies which skills it requires to discharge its responsibilities most effectively.	The appointment of NEDs to the board is led by Welsh Government, however WAST does take account of our skills mix on selection, and those skills are referred to by the ARAC chair on appointment of new members to ARAC. Prescribed attendees are selected for their skills and experience including that of governance, risk and control.
	2.1.4	The required skill sets for the ARAC are reviewed at regular intervals.	The membership of ARAC is updated annually in line with the review of its terms of reference
Good Practice	**2.1.5**	The ARAC draws on a sufficiently diverse membership, containing a variety of demographic attributes and characteristics.	Whilst we use the skills matrix, we do not seek and retain diversity information for all members of ARAC and the board. NED appointments take account of the need for diversity, however WAST is limited in its control of this process as NED appointments are managed by Welsh Government. The board will be participated in the Welsh Government Aspiring Board Members Programme in 2025/26.
	2.1.6	The ARAC documents and maps the skills of its members so it can identify areas of strength and any skills gaps.	Currently only board members are included on the skills mix. However prescribed attendees who are not part of that skills mix are selected for their skills and experience including that of governance, risk and control.
	2.1.7	The financial reporting expertise held by members is relevant and appropriate to the significant financial reporting risks of the organisation – particularly in respect of any complex estimates or judgements.	The Chair of ARAC and the Executive Director of Finance and Corporate Resources are qualified accountants, as was the acting Director of Finance and Corporate Resources who acted in that role during 2025/26.
	2.1.8	The ARAC benefits from a good mix of non-technical skills – for example, communication, influencing, negotiating, leadership and facilitation skills.	Members are appointed to ARAC based on their skills and experience relevant to the committee. Many of these members, particularly those in senior positions and our NEDs, possess these skills.
	2.1.9	The ARAC uses the powers of co-opting members and procuring specialist skills where these were required.	Independent advisors or specialists can be invited to meetings as required. The board skills mix document is updated regularly to ensure we have the right spread of membership across committees and ARAC. Expertise is brought in during development for board or committees.
Training and development			
Essentials	**2.2.1**	Members who have recently joined the ARAC have been provided with induction training to help them understand their role and the organisation.	See 1.1.7 above
	2.2.2	Members of the ARAC who are unfamiliar with corporate governance and wider practice in government are specifically upskilled in this area.	See 1.1.7 above
	2.2.3	Members keep their skills and knowledge up to date through networking and conferences to allow them to focus on key issues facing the organisation.	Audit Wales alerts ARAC to relevant information; the ARAC Chair chairs the All Wales Audit Chairs Group where Audit Wales and Internal Audit also present; Members attend regular board development and board visits.
	2.2.4	The ARAC chair ensures that members have an appropriate programme of engagement with the organisation and its activities to help them understand the organisation, its objectives, business needs, priorities and risk profile.	As 2.2.1 and 2.2.2. Also, there is a Board Visits SOP which encourages members to engage with the organisation as a way of understanding it more deeply and triangulating assurance. ARAC members sit across a number of other board committees also.
Good Practice	**2.2.5**	There is a positive culture of learning and personal development within the ARAC.	This was discussed at the 6 March 2025 meeting. ARAC members continued to meet regularly through the year to review effectiveness and in particular the spread of board committees. ARAC's focus on the structures and streamlining of committees have been examples of continuous improvement and learning in ARAC in 2025/26
	2.2.6	The ARAC's strategy for training and development takes account of developments in corporate governance and emerging risk areas.	See 1.1.7, 2.2.3 and 2.2.5 above, but also the Audit Wales update report includes horizon scanning and articles of relevance to the NHS in Wales.
	2.2.7	For ARAC members unfamiliar with the operations of government and the public sector, special focus is given to this as part of their training programme	N/A for WAST

	2.2.8	The ARAC chair attends cross-governmental (if a government department) or cross-departmental (if an arm's-length body) ARAC chair meetings.	N/A for WAST
Other skills - Cyber & Digital			
Good Practice	**2.3.1**	The ARAC understands how cyber and digital risks impact on the organisation.	FPC holds the digital remit for the board and whilst ARAC reviews the cyber risks, it is FPC that reviews these in more detail. ARAC has the opportunity to review the impact of risks on the organisation through the regular reporting of the principal risks. This sets out the risks in an 'if', 'then', 'resulting in' format which is accomanied by the controls, gaps and mitigating actions to reduce the risk and impact. AAA reports from the closed FPC meeting where cyber is discussed are reviewed by ARAC and board members.
	2.3.2	The ARAC has the level of skills and expertise required to challenge management, and provide assurance to the Board that the organisation is properly managing its cyber and digital risks.	Oversight of IG and cyber security currently sits in the remit of the Finance and Performance Committee, however this may move to ARAC in 2026/27 subject to evaluation of committee structures by GGI. If this occurs the committee may wish to hold a development session to upskill members. Notwithstanding this, it is open to all committees to seek specific induction/development sessions for areas in their purview. The board has received cyber training in the past. The Finance and Performance Committee includes the SIRO and Caldicott Guardian, as well as the digital NED champion.
Other skills - Climate change and ESG			
Good Practice	**2.3.3**	The ARAC is satisfied the organisation's approach to managing ESG risks, and making appropriate disclosures, is in line with relevant standards such as the Greening Government Commitments and Sustainability Reporting Guidance.	FPC holds the environmental and sustainability remit for the board and ARAC members have access to the AAA reporting from FPC to the board on these issues. ARAC also reviews the annual disclosure statements that are relevant as part of the annual report. PCC holds risks related to labour and workforce with the board holding the risk to reputation from partnerships and external relationships. ARAC members have access to the AAA reporting from PCC on these issues and risks. Governance risks such as standards of business conduct and board effectiveness are managed by ARAC as stated above re declarations of interest etc., as well as annual committee effectiveness reviews scrutinised by the committee
	2.3.4	The ARAC is able to effectively assess the organisation's approach to managing climate related risks.	See 2.3.2 but as it is relevant for adaptation planning (Finance and Performance Committee)
	2.3.5	The ARAC assesses the organisation's net zero strategy with sufficient detail, and at regular intervals.	See 2.3.2 but as it is relevant for decaronisation and sustaintability (Finance and Performance Committee)
Other skills - Projects and programmes			
Good Practice	**2.3.6**	The ARAC is appropriately sighted on significant projects and programmes throughout their lifecycle.	Programmes specific to ARAC (such as the risk transformation programme in 2024/25 and the integrated governance programme in 2025/26) are monitored by ARAC. Other programmes of work are monitored where relevant by other board committees.
	2.3.7	The ARAC has the skills and expertise to provide effective critical challenge on the financial management, delivery risks and overall progress of projects or programmes.	The appointment of NEDs to the board is led by Welsh Government, however WAST does take account of our skills mix on selection, and those skills are referred to by the ARAC chair on appointment of new members to ARAC. Prescribed attendees are selected for their skills and experience including that of finance, governance, risk and control.
Other skills - Procurement			
Good Practice	**2.3.8**	The ARAC has an appreciation of the risks associated with procurement in the public sector context.	Given the recently changed rules around procurement and the large financial commitments the Finance and Performance Committee are asked to endorse for the board, this may be an area they wish to do a more detailed review of if they have capacity in 2026/27, particularly the identification of risks related to this area.
	2.3.9	The ARAC has the skills and expertise to challenge commercial activities and the procurement of goods and services.	As 2.3.8 given that Finance and Performance Committee are usually the first port of call for a challenge to procurement of goods and services, and hold the commercial remit.
3. Roles and Responsibilities			
Assurance			

Essential	**3.1.1**	The ARAC helps the accounting officer and Board to formulate their assurance needs.	ARAC recently revised its title to include this important 'assurance' arm to ensure it has more focus on this. The board assurance framework is an important element of assuring the accounting officer and the board in this regard, however the elements of the BAF that relate to strategic objectives has not yet developed sufficiently to provide full assurance on this. Hveing said that, the principal risks that ARAC receives have started to show assurances against the three lines of defence model. The integrated governance programme had intended to provide an additional layer of assurance linked to the quality and performance management framework in 2025/26 however due to resource constraints the accountability and assurance handbook has been delayed. The annual audit plan from Internal Audit and from Audit Wales also allows ARAC to test strengths of internal controls and assurance, as does the annual report and audited accounts.
	3.1.2	The ARAC assesses whether the assurance received is of sufficient quality to meet the assurance needs outlined in 3.1.1.	See 3.1.2
	3.1.3	The ARAC understands the key sources of assurance in the organisation, and how and why each of these sources provide assurance to them.	Members of ARAC are familiar with the three lines of defence model, and these are drawn out in the Risk Management Policy.
	3.1.4	The ARAC understands the three lines of defence model, and how this applies in practice to the organisation.	As above 3.1.3
	3.1.5	The ARAC is proactive in commissioning assurance work from appropriate sources where it identifies any significant risk, governance and control issues which have not been subject to sufficient review.	This was demonstrated in 2025/26 when the committee challenged the trust to streamline its committee structures and were closely involved in this work unfolding. ARAC members have input into the annual internal audit plan and approve that plan on behalf of the board
	3.1.6	The ARAC ensures the organisation operates appropriate and effective whistleblowing practices, and this is regularly considered by the ARAC.	The oversight and monitoring of arrangements for Speaking Up Safely sit with PCC. ARAC receives assurance from the Chair of PCC annually on arrangements and did so in 2025/26.
Good Practice	**3.1.7**	The ARAC uses assurance mapping to identify where assurance is required to identify any key gaps where no assurance is provided, or where the quality of the assurance is poor.	There is more work to be done here, and the integrated governance work and the strategic BAF will strengthen this
	3.1.8	The ARAC has an effective system for monitoring management's progress with recommendations from internal and external sources.	The audit tracker is received at each ARAC meeting and each Committee meeting. Directors appear where their actions are on a third and final date.
Governance			
Essentials	**3.2.1**	The ARAC understands the Board's operating framework, including the organisation's vision and purpose.	ARAC members are aware of the Trust's IMTP and the process for developing it.
	3.2.2	The ARAC understands the mechanisms which ensure effective organisational accountability, performance and risk management.	ARAC had oversight of the QPMF in 2024/25 which now sits in FPC. The accountability handbook will help understanding further, however the ARAC has a good understanding of the standing orders and delegations, as well as risk management.
	3.2.3	The ARAC understands the role definitions, committee and other structures which support effective discharge of responsibilities, decision making and reporting.	ARAC receives the effectiveness reviews for all committees annually ahead of their presentation to board. ARAC assures the board that the committees are operating effectively, and have appropriate decision making and reporting process.
	3.2.4	The ARAC understands how appropriate ethics and values are promoted within the organisation.	ARAC has oversight of the Standards of Business Conduct Policy.
	3.2.5	The ARAC understands how management information is communicated to the Board and other appropriate areas of the organisation.	ARAC receives the effectiveness reviews for all committees annually ahead of their presentation to board. ARAC assures the board that the committees are operating effectively, and have appropriate decision making and reporting process. Further work from the integrated governance programme which maps the internal governance structure was reviewed in 2025/26 and tiering principles agreed. Further work is planned in order to gain stronger assurance in this area
	3.2.6	The ARAC understands the nature of relationships with arm's-length bodies, if applicable.	WAST does not have arm's length bodies
Good Practice	**3.2.7**	Without duplicating the work of the Board, the ARAC advises on – and scrutinises the implementation of – its organisation's corporate governance policy.	WAST does not have a stand alone corporate governance policy. The corporate governance framework within which WAST operates is in our standing orders and is set out in our annual report which is endorsed by the ARAC for board approval.
	3.2.8	The ARAC reconciles assurance from internal and external audit and other sources of assurance with conclusions drawn in the organisation's annual governance statement.	Confirmed. HOIA is also taken account of and included in the annual governance statement.
	3.2.9	The ARAC monitors developments in corporate governance so it can proactively advise the Board and accounting officer on any changes to assurance requirements.	See 3.2.8 and as issues arise during the year
Risk management			

Essentials	**3.3.1**	The ARAC understands the organisation's business strategy, operating environment and the associated risks to executing the strategy.	ARAC members are aware of the Trust's IMTP and the process for developing it. The BAF currently maps risks to IMTP deliverables and their related strategic objectives. Risk appetite statements were approved in 2025/26 with the BAF developing in 2026/27 and beyond.
	3.3.2	The ARAC is satisfied that management takes an enterprise-wide view of the organisation's risks, including those that cross organisational boundaries.	ARAC receives the risk register at each meeting which takes an organisational wide view of the Trust's principle risks. Where risks cross over to health bodies, those mitigations within WAST's control are drawn out in the risk.
	3.3.3	There is a clear understanding of the role and activities of the Board in relation to managing risk.	The risk management policy sets out roles and responsibilities. ARAC are satisfied that these are known and understood.
	3.3.4	The ARAC discusses with the Board how its policies, attitude to, and appetite for risk are defined and communicated across the organisation.	Risk appetite statements were approved in 2025/26 as was the approach to their use (March 2026)
	3.3.5	The ARAC understands and challenges the risk management framework and the assignment of responsibilities.	The risk management policy sets out roles and responsibilities. ARAC are satisfied that these are known and understood.
	3.3.6	Adequate assurance has been obtained on the risk and control environment encompassing services outsourced to external providers, including shared service arrangements, and the wider supply chain.	Internal audit services are supplied by NWSSP Internal Audit and procurement by NWSSP Procurement. A number of other service including payroll etc., are also managed by NWSSP. A recent governance and assurance review of NWSSP confirmed that the governance arrangements in place are appropriate and recommended actions taken on the application of those arrangements to strengthen assurance. NWSSP Procurement will undertake a piece of work on training etc for contract management following the 2024/25 contract management audit.
	3.3.7	(For government departments and groups only) assurance has been obtained on risks from across the group – and there is timely communication and visibility of these risks.	N/A for WAST
Good Practice	**3.3.8**	The ARAC promotes the importance of a positive risk culture in the organisation	ARAC approved the risk management policy where roles and responsibilities were clearly set out. It has supported the risk transformation programme since 2022 and champions the strategic BAF and risk appetite work in committee and to the board when reporting on its work.
	3.3.9	The ARAC challenges management on whether there is a comprehensive process for identifying and evaluating risk, and for deciding what levels of risk are tolerable.	ARAC approved the risk management policy where roles and responsibilities were clearly set out. ARAC led the work to develop risk appetite in 2025/26 and will do so with respect to risk tolerance in 2026/27.
	3.3.10	The ARAC has sufficient understanding of the organisation to assess whether the risk register is an appropriate reflection of the risks facing the organisation.	ARAC members also attend Trust Board as well as a number of other committees where they are well placed to understand the principle risks facing the organisation. They are well inducted as board members, and are encouraged to undertake board visits where they are able to triangulate assurance information on risk. As board members they receive each committee's AAA reports which set out the risks reviewed.
	3.3.11	The ARAC can assess whether there are sufficient resources to manage risk effectively across the organisation.	Regular reporting on risk management is taken to ARAC, including the resource requirements for effectiveness risk management at WAST.
	3.3.12	The ARAC challenges whether management's approach to identifying risks is broad enough to effectively identify new and emerging risks.	The risk management policy have roles and responsibilities clearly set out. Escalation is currently through directorates to the ELT before going on to committees. For principal risk this is centrally managed by the risk team.
	3.3.13	The ARAC challenges management on its approach to evaluating risks, including the effectiveness of scenario planning and stress testing.	The BAF includes all the detail required for ARAC to understand the rationale for risk ratings and the actions to mitigate risk. More work is planned under the new strategic BAF to enable ARAC to evaluate strength of internal controls in place.
	3.3.14	The ARAC reviews information on 'near misses' to help determine whether the systems in place are sufficiently robust to mitigate future risk events.	Near miss reporting is within the QUEST remit, however the chair of QUEST reports to ARAC annually on this.
	3.3.15	The ARAC understands the main fraud and error risks and entry points, and challenges management to consider timely options for tackling fraud and error risks.	ARAC receives a report from the Local Counter Fraud Service at each of its closed meetings and is able to scrutinise assurance and ask questions of the LCFS lead.
	3.3.16	The ARAC considers the impact of risks and how these could impact on the ongoing resilience of the organisation.	The BAF includes all the detail required for ARAC to understand the impact of the principle risks, with the risks being articulated in the 'if', 'then', 'resulting in' format. .
Internal control			
Essentials	**3.4.1**	The ARAC critically challenges and reviews the adequacy and effectiveness of control processes in responding to risks.	Controls to mitigate risks are set out in the BAF. Assurance on controls is referenced along the three lines of defence. More work is to be done with the strategic BAF to rate assurances, but this will take some time.
	3.4.2	The ARAC challenges whether the extent of the controls in place to mitigate risks are excessive, and whether any action is needed to address this.	The BAF includes all the detail required for ARAC to understand the rationale for risk ratings and the actions to mitigate risk. More work is planned under the new strategic BAF to enable ARAC to evaluate strength of internal controls in place. Risk appetite statements will allow ARAC members to more readily access if mitigations are excessive relative to tolerance.

Good Practice	**3.4.3**	The ARAC has a good understanding of how the organisation develops, operates and monitors the system of internal control.	Not only is this assurance given through the year via risk and policy reports, internal and external audit reports, ARAC reviews the annual report and audited financial accounts each year to gauge the strength of the internal controls and provides assurance to the board on this.
	3.4.4	The ARAC seeks assurance on how any material or significant risks are managed through strategic, operational and compliance controls.	Controls to mitigate risks are set out in the BAF. Assurance on controls is referenced along the three lines of defence. More work is to be done with the strategic BAF to rate assurances, but this will take some time.
	3.4.5	The ARAC assesses whether the system of internal control would provide timely indicators of weaknesses and failings.	The BAF includes all the detail required for ARAC to understand the rationale for risk ratings and the actions to mitigate risk. More work is planned under the new strategic BAF to enable ARAC to evaluate strength of internal controls in place. HoIA opinion will provide indicators of this also.
	3.4.6	When any significant failings or weaknesses in internal control arise, the ARAC reviews management's analysis of the root cause and subsequent action plan.	The BAF includes all the detail required for ARAC to understand the rationale for risk ratings and the actions to mitigate risk. The controls are updates in line with the review schedule agreed by ARAC and new and changed actions delineated for ARAC's attention.
	3.4.7	The ARAC is satisfied that the organisation has a sound system of financial control – including the structure of delegations – which enables the organisation to achieve its objectives with good value for money.	ARAC endorses any changes to the Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation to Officers, and committee terms of reference. As set out above, ARAC reviews the annual report and audited financial accounts each year to gauge the strength of the internal controls and provides assurance to the board on this.
	3.4.8	The ARAC has sufficient assurance over the quality of IT controls.	FPC holds the digital remit for the board and it is FPC that reviews these in more detail. ARAC are assured via the FPC AAA report to board.
	3.4.9	The ARAC is satisfied that the organisation's controls are designed to effectively prevent and detect known fraud and error risks.	ARAC receives a report from the Local Counter Fraud Service at each of its closed meetings and is able to scrutinise assurance and ask questions of the LCFS lead.
	3.4.10	The ARAC has oversight of how controls are evaluated so it can understand how effectively fraud and error risks are being addressed.	ARAC receives a report from the Local Counter Fraud Service at each of its closed meetings and is able to scrutinise assurance and ask questions of the LCFS lead.
Financial reporting			
Essentials	**3.5.1**	The ARAC reviews the clarity and completeness of disclosures in the year-end financial statements.	Confirmed
	3.5.2	The ARAC uses its understanding of the organisation to assess whether disclosures in the financial statements are set properly in context.	Confirmed - as set out above, ARAC is well placed to do so given its remit and its cycle of business.
	3.5.3	The ARAC specifically considers key accounting policies and disclosures.	Confirmed - these are included as part of the committee's cycle of business.
	3.5.4	The ARAC specifically considers assurances about the financial systems which provide the figures for the accounts.	The accounts are audited by Audit Wales and ARAC receives their audit report and ISA260.
	3.5.5	The ARAC specifically considers the quality of the control arrangements for preparing the accounts.	ARAC receives assurance on the control environment via the Executive Director of Finance and Corporate Resources in the lead up to their endorsement, including any issues arising if relevant. The annual report is prepared under a task and finish arrangement with finance representation. ARAC approves any financial control policies and procedures, and scrutinises any related internal audits. The annual structured assessment from Audit Wales reviews the financial governance arrangements at WAST.
	3.5.6	The ARAC specifically considers key judgements made in preparing the accounts, and management's consideration of their ongoing relevance.	See 3.5.5
	3.5.7	The ARAC specifically considers any disputes arising between those preparing the accounts and the auditors.	See 3.5.5. ARAC meets privately with auditors to enable such conversations to take place.
	3.5.8	The ARAC specifically considers reports, advice and findings from external audit – especially the Audit Completion Report.	See 3.5.5, but also ARAC receives an update report from Audit Wales quarterly, and the structured assessment and deep dive work annually.
	3.5.9	The ARAC assures itself that accounting policies comply with relevant requirements, particularly HM Treasury's Financial Reporting Manual.	The accounts for the year end are prepared to comply with International Financial Reporting Standards (IFRS) adopted by the European Union, in accordance with HM Treasury's FReM under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directs.
	3.5.10	In addition to receiving a detailed overview from the Finance Director, the ARAC is confident that the organisation's approach to preparing the accounts is sufficiently rigorous.	See 3.5.5
	3.5.11	The ARAC challenges that the Annual Report is fair and balanced.	ARAC members receive the annual report in draft form ahead of the meeting to endorse it and their comments and challenge are specifically sought.
	3.5.12	Where novel accounting issues, or complex judgements have arisen during the year, the ARAC has satisfied itself that management took specialist advice or enlisted expertise.	Were it to arise it would do so. The Executive Director of Finance and Corporate Services keeps the Chair of ARAC informed of any upcoming complex judgements or changes in accounting policies or practices in their regular 1:1s.
	3.5.13	The ARAC is satisfied with management's processes for identifying and responding to the risks of fraud.	ARAC receives a report from the Local Counter Fraud Service at each of its closed meetings and is able to scrutinise assurance and ask questions of the LCFS lead.
	3.5.14	The ARAC is effective in monitoring significant financial reporting issues throughout the year, particularly those which could lead to qualification of the accounts.	This has not arisen in 2025/26, but if that was the case it would do so.

Good Practice	**3.5.15**	In reaching a view on the accounts, the ARAC considered the implications of reports from third parties – for example, on legal matters, valuations, or reports from regulators.	This has not arisen in 2025/26, but if that was the case it would do so.
	3.5.16	The ARAC considers key matters on their own initiative rather than relying solely on the work of the external auditor.	ARAC's consideration of the accounts takes account of the full range of assurance reporting throughout the year, as well as the work of Audit Wales and their assurances.
	3.5.17	The ARAC has a detailed understanding of the organisation and its context and can successfully challenge whether the accounts provide a fair representation of activity.	ARAC members also attend Trust Board as well as a number of other committees where they are well placed to understand the principle risks facing the organisation. The Chair and the Executive Director of Finance and Corporate Resources are qualified accountants and would discuss such isues at their 121s
	3.5.18	The ARAC sufficiently challenges the going concern assessment in the context of its review of the financial statements and understanding of the business.	This has not arisen in 2025/26, but if that was the case it would do so.
	3.5.19	The ARAC offers appropriate challenge to any information which is generated through financial modelling.	This has not arisen in 2025/26, but if that was the case it would do so.
	3.5.20	The ARAC is up-to-speed with developments in financial reporting standards and can challenge their application in financial statements.	The Chair and the Executive Director of Finance and Corporate Resources are qualified accountants and would discuss such isues at their 121s.
	3.5.21	(For departments or groups only) the ARAC has sufficient oversight of significant financial reporting risks from across the department or group.	N/A for WAST
4.Scope			
Terms of reference			
Essentials	**4.1.1**	The Audit and Risk Assurance Committee's terms of reference are agreed by the Board.	Confirmed.
	4.1.2	The terms of reference are reviewed regularly and at appropriate intervals.	Confirmed. This occurs annually.
	4.1.3	The terms of reference do not conflict with guidance in HM Treasury's Audit and Risk Committee Handbook.	Confirmed.
	4.1.4	The terms of reference make clear the ARAC's independence as a Committee.	Confirmed.
	4.1.5	The ARAC's terms of reference are made publicly available, including on the organisation's website.	Confirmed.
	4.1.6	The terms of reference allow for the ARAC to sit privately without any non-members present for all or part of a meeting if they wish.	The TOR was amended in 2025/26 to reflect this requirement, however there has not been a need this year for the Chair to formally convene a meeting without the presence of management.
	4.1.7	The ARAC terms of reference cover details of the ARAC membership.	Confirmed.
	4.1.8	The ARAC terms of reference cover reporting requirements to the Board.	Confirmed.
	4.1.9	The ARAC terms of reference cover the key areas of responsibility the ARAC will advise the Board and accounting officer on.	Confirmed.
	4.1.10	The ARAC terms of reference cover the rights of the ARAC over co-opting additional members or procuring specialist advice.	Confirmed.
	4.1.11	The ARAC terms of reference cover the head of internal audit and a representative from external audit will have free and confidential access to the chair of the ARAC.	Confirmed.
	4.1.12	The ARAC terms of reference cover meeting information, including the number per year, the number of members required for the meeting to be quorate, and expected invitees.	Confirmed.
	4.1.13	The ARAC terms of reference cover information requirements, including what information will be provided for each meeting, and what will be provided on request.	This is contained in the accompanying cycle of business
Good Practice	**4.1.14**	The ARAC has compared its terms of reference against those of similar profile organisations.	Confirmed.
	4.1.15	In addition to core requirements, the terms of reference contain information which allows the ARAC to function more effectively – for instance, expectations about how far in advance of meetings papers will be provided.	Confirmed and aligns with Standing Orders.
	4.1.16	The terms of reference properly reflect the role and scope of the ARAC, and are proportionate to the way the ARAC actually operates.	Confirmed.
Internal Audit			
Essentials	**4.2.1**	The ARAC performs a risk-based review of internal audit's strategy and plan.	The annual plan is based on our principle risks and is developed with ARAC and approved by ARAC.
	4.2.2	The ARAC assesses the adequacy of the budget and resources available to internal audit.	The Internal Audit fee is agreed by ARAC annually.
	4.2.3	The ARAC have reviewed the internal audit charter or terms of reference.	ARAC approves the Internal Audit Charter.
	4.2.4	The ARAC assesses the results of internal audit's work, and management's responses to the issues raised.	ARAC receives internal audit reports and the internal audit update at each meeting and the relevant director is present for each audit report presented.
	4.2.5	The ARAC reviews the annual internal audit opinion and associated annual report.	Confirmed.
	4.2.6	The ARAC assesses the performance of internal audit against applicable standards, expected performance measures, and the results of any internal or external quality assurance assessments.	The internal audit update provides performance metrics for internal audit and WAST

Good Practice	**4.2.7**	The ARAC frames the work of internal audit in the context of other assurance activity that takes place in the first and second lines of defence.	When agreeing the annual audit plan ARAC will view this with the principle risks in mind and welcome the third line of defence review. When the strategic BAF is developed this will mature to inform the annual audit plan further.
	4.2.8	The ARAC is proactive in tracking that the recommendations agreed by management are actually implemented.	The audit tracker is received at each ARAC meeting and each Committee meeting. Directors appear where their actions are on a third and final date.
	4.2.9	The ARAC plays a role in providing support for, and acceptance of, the work of internal audit.	Internal audit is a feature of each agenda of ARAC. In addition, the Chair meets privately before ARAC meetings with the leads from internal audit and Audit Wales.
	4.2.10	The ARAC challenges whether the effectiveness of the risk, compliance and finance functions is evaluated as a part of its internal audit strategy.	The annual plan is based on our principle risks and is developed with ARAC and approved by ARAC.
	4.2.11	The ARAC considers how the individual components of the annual internal audit plan provides reasonable assurance on risk, control and governance for the organisation in totality.	The annual plan is based on our principle risks and is developed with ARAC and approved by ARAC. Internal audit reports conclude a rating of assurance from no assurance to substantial assurance on set objectives relative to the audit.
External Audit			
Essentials	**4.3.1**	The ARAC considers and makes relevant enquiries about the external auditor's planned audit approach.	The Audit Wales annual plan is presented to ARAC annually and updated quarterly.
	4.3.2	The ARAC considers the impact of the results of external audit work.	The annual structured assessment from Audit Wales and any deep dives are reviewed in detail by ARAC and actions to address any issues monitored by ARAC and other committees.
	4.3.3	The ARAC promotes co-operation between the external auditor and internal audit to maximise overall audit efficiency, capture opportunities to derive a greater level of assurance, and minimise unnecessary duplication of work.	Internal audit and Audit Wales coordinate their annual plans to ensure reduced overlap. The ARAC Chair meets with the auditors together privately ahead of each ARAC meeting to support that cooperation and scrutinise accordingly.
	4.3.4	The ARAC reviews and considers any implications for the organisation of the wider work carried out by the external auditor, for example, value-for-money reports or good practice findings.	Audit Wales report on such work in their quarterly updates. System related Audit Wales reports will also come through ARAC where related.
Good Practice	**4.3.5**	The ARAC has a clear understanding of the objectives, scope and remit of external audit work.	Confirmed. As indicated above, they received their annual audit plan and regular updates.
	4.3.6	The ARAC reviews the scope of external audit work and – if not satisfied as to its adequacy – challenges whether additional work should be undertaken by the external auditor.	There is an opportunity to do this when presented with their annual plan, although this has not occurred in 2025/26.
	4.3.7	The ARAC satisfies itself that the level of fees payable in respect of the audit services provided is appropriate and that an effective, high quality audit could be conducted for such a fee.	The Audit Wales fee is agreed by ARAC.
	4.3.8	The ARAC is satisfied that it has a good understanding of materiality, including the benchmarks used and the calculation of materiality and performance materiality.	The materiality benchmark is drawn out for ARAC and members have a good understanding of how that is applied in the annual audit of the financial statements
	4.3.9	The ARAC considers factors that could affect the quality of the audit during the year and discusses these with the auditor.	This has not occurred in 2025/26 but there is opportunity to do so should that be required.
	4.3.10	The ARAC is satisfied that the external auditor has access to relevant expertise, for instance around pensions liabilities or property valuation.	Audit Wales draw on the expertise of their teams in these matters and where relevant those experts present their findings
	4.3.11	The ARAC focusses on priority issues when undertaking its review of the results of external audit work.	ARAC bears in mind the principle risks to the organisation and the wider system when receiving the annual audit plan.
	4.3.12	The ARAC reviews the audit representation letters before they are signed by the accounting officer and gives particular consideration to matters where representation has been requested that relates to non-standard issues.	Confirmed
	4.3.13	The ARAC takes steps to ensure external audit receives quality, robust and timely audit evidence from the finance function.	Cooperation with Audit Wales is excellent so this intervention has not been required from ARAC, but there is the opportunity for them to do so if required.
	4.3.14	The ARAC is supportive of external audit's challenge of management and does not act as management's advocate.	ARAC members maintain independence as far as this is concerned and ensure a balanced view of the accounts and all structured assessment work and recommendations.
	4.3.15	The ARAC reviews and monitors management's responsiveness to the external auditor's findings and recommendations.	The responses are reviewed when the reports are received in ARAC and monitored by ARAC and other committees via the audit tracker.
5.Communication and reporting			
Communications and reporting			
Essentials	**5.1.1**	The ARAC produces a report after each meeting for the Board and accounting officer (with a copy to the head of internal audit and the external auditor) covering: - the key business taken by the ARAC, and - the ARAC's views and advice on any issues they believe the Board or accounting officer should take action on.	The AAA report from ARAC to board is completed within 48 hours and distributed to the board and ARAC members soon afterwards. The AAA is published on the Trust's website at the same time for public view.
	5.1.2	The ARAC has effective communications with those it seeks briefings from (the executive and internal and external audit) and those it provides assurance to (the Board).	ARAC has noted a number of times during 2025/26 on the clarity of the papers and presentations.
	5.1.3	The ARAC provides an Annual Report timed to support the preparation of the Governance Statement.	ARAC prepares its annual report to the board in May each year and the detail supports the view on board and committee effectiveness in the AGS.
	5.1.4	The ARAC's Annual Report is open and honest in presenting the ARAC's views.	ARAC members receive the annual report in draft form ahead of the meeting to endorse it and their comments and challenge are specifically sought.

	5.1.5	The ARAC's Annual Report summarises the ARAC's work for the past year and how it discharges its responsibilities in accordance with the HM Treasury's ARAC Handbook.	ARAC prepares its annual report to the board in May each year and the detail supports the view on board and committee effectiveness in the AGS.
	5.1.6	There are mutual rights of access between each of the chair of the ARAC, the accounting officer, head of risk management (if a separate function), head of internal audit and the external auditor.	The Chair of ARAC has regular 1:1 meetings with the Executive Director of Finance and Corporate Resources, the Director of Corporate Governance, and the auditors (internal and Audit Wales). These individuals have free flowing access to the ARAC Chair.
	5.1.7	There are periodic discussions with key attendees outside of the formal meetings to help ensure that expectations are managed and there is mutual understanding of current risks and issues.	See 5.1.6 and in addition NEDs meeting monthly and any issues and risks can be raised there also with the ARAC chair.
Good Practice	**5.1.8**	The ARAC reports its work as transparently as possible within the limits of what is confidential and commercially sensitive.	The AAA report from ARAC to board is completed within 48 hours and distributed to the board and ARAC members soon afterwards. The AAA is published on the Trust's webstie at the same time for public view. The work taken in closed ARAC is reported in open board at a high level.
	5.1.9	The ARAC has a robust mechanism for working with the Board, so expectations and accountability is clear.	See 5.1.8 and the approved terms of reference where are clear on roles and responsibilities.
	5.1.10	The ARAC uses technology to its advantage and communicates as a group in a way which is effective and efficient.	The AAA report takes advantage of IG safe tools to ensure it is developed in a timely way. Papers for meetings are uploaded to Ibabs and the board website for ease of access.
	5.1.11	The reports received by the ARAC are the right level of detail, and presented in a manner which makes it easy for members to review and challenge.	ARAC has noted a number of times during 2025/26 on the clarity of the papers and presentations.
	5.1.12	Reports produced by the ARAC are proportionate: there is enough information to provide the Board with the assurance it requires, but not too much that key information is diluted.	See 5.1.8. The board has been satisfied with the level of detail from ARAC.
	5.1.13	(For government departments only) the departmental ARAC has an effective way of gaining visibility over key risks and issues arising from ARACs within the departmental group.	N/A for WAST
6.Continual improvement			
Continual improvement			
Good Practice	**6.1.1**	The Chair seeks appraisal of his or her performance from the Accounting Officer or Chair of the Board, as appropriate.	This has takes place with the Chair.
	6.1.2	The Chair assesses the performance of the individual members of the committee, discusses their training and development needs, and agrees a training and development plan.	We do not believe that formal performance reviews of ARAC members is necessary in addition to their appraisals with the Chair of the Board. However, periodic catch-ups to discuss how ARAC is performing, assessing any training or developmental needs plus any other issues was felt to be beneficial.
	6.1.3	The Chair ensures a periodic review of the overall effectiveness of the ARAC.	Agreed this should be done as part of the ARAC Annual Report to the Board.
	6.1.4	After completing an effectiveness review, there is sufficient time and effort devoted to discussing results, and agreeing an action plan based on the outcomes.	Time is devoted to this in the ARAC meeting, and a review of the resultant annual report and terms of reference.
	6.1.5	Evaluation of performance is not done in isolation, and year-on-year trends in different areas of performance is measured.	This has occurred in the past, however it is not always a good representation of progress, especially using this NAO questionnaire. ARAC has therefore taken a different approach to effectiveness reviews focused more on assurance and remit of committees.
	6.1.6	The Chair considers ways in which to obtain feedback from the executive and other key stakeholders – for example, internal and external audit – on the performance of the ARAC.	A feedback questionnaire is part of the quality and governance review in 2025/26
	6.1.7	The results of the performance evaluation are used to inform and influence succession planning - for instance in highlighting skills gaps, or a lack of diversity.	We acknowledged that we cannot cover all bases, and will highlight at agenda setting where we feel there are skills gaps in relation to certain work areas/reports coming to ARAC and will proactively ensure as best we can that the appropriate resources are obtained to apply proper scrutiny.
	6.1.8	The ARAC carefully considers the extent and method of performance evaluation – for instance, whether aspects could be externally facilitated.	An externally facilitated effectiveness review of the board and of its committee structures will take place in Q4 25/26 and Q1 26/27
	6.1.9	The evaluation of performance is objective and rigorous enough for meaningful conclusions to be drawn.	ARAC is of the view that sufficient time is given over in all committees to the evaluation of their effectiveness during the year as a continuous improvement model, as well as annually.

Agenda Item No.	08

REPORT TITLE

Risk Management and Board Assurance Framework Report

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	02 March 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Governance / Board Secretary
Author(s) of report	Julie Boalch, Assistant Director of Corporate Governance & Risk

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This report provides assurance on the management of the Trust's principal risks and progress against the 2025/26 risk management work programme, alongside priorities for 2026/27.

Principal Risk Activity

2. The report demonstrates that the Trust's principal risks continue to be actively reviewed by Directors and the Executive Leadership Team, in line with the agreed schedule, with assurance provided through Committee oversight and the Alert, Assure, Advise (AAA) mechanism.

3. During this reporting period, there has been sustained focus on the Trust's highest rated risks with all principal risk activity considered by the ELT on 28 December 2025. All principal risks remain under close review.

4. The report highlights a reduction in the score for Risk 223 *The Trust's inability to reach patients in the community causing patient harm and death* from 25 (5x5) to 20 (4x5) reflecting the impact the strengthening of internal controls, implementation of the Clinical Transformation Model and improvements in system oversight.

5. Risk 623 *Failure to comply with Data Protection Legislation*, has achieved its target score of 10 (2x5) reducing from 15 (3x5) and will be de-escalated from the Board Assurance Framework (BAF) for ongoing management at a Directorate level.

Risk Appetite Statements

6. The Board approved the suite of Risk Appetite Statements (RAs), at its meeting on 27 November 2025, which represents a significant step forward in setting out the level and type of risk the Board is willing to take in pursuit of its strategic objectives The report sets out the next steps for embedding risk appetite into decision making and assurance oversight, including the development of tolerances, thresholds, monitoring metrics and reporting mechanisms during 2026/27.

High Level Summary of the 2025/26 Work Programme and Progress

7. Progress against the 2025/26 programme is positive, with key milestones delivered, including:
   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 *(Complete)*
   f. November/December 2025: Proof of Concept for new Electronic Risk Management System *(Ongoing)*

Board Level Risk Reporting / Strategic Board Assurance Framework

8. The Trust is developing a refreshed Strategic Board Assurance Framework aligned to its strategic objectives. As an interim measure, a revised approach to Board level risk reporting is proposed, aligning the Trust's highest scoring risks more closely with the Avoidable Harm report. This will enhance Board visibility of the most significant sources of avoidable harm while avoiding duplication, recognising that detailed scrutiny of principal risks already occurs at Committee level.

9. The Committee is asked to consider the proposed approach to Board level risk reporting, note progress against the 2025/26 work programme, consider the forward programme for 2026/27, and take assurance on the continued active management and oversight of the Trust's principal risks.

10. Members are asked to note the work undertaken to develop a strategic risk against Strategic Objective 2 – enabling our people to be the best that they can be.

Risk Management Policy

11. The updated Risk Management Policy is before Committee today for endorsement. This has been updated to reflect the Trust's Risk Appetite.

Annual Reporting

12. Work is underway on the 2025/26 Risk Management Internal Audit which is expected to be presented to the June Committee. The 2026/27 Risk Reporting schedule is included for information.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Audit, Risk and Assurance Committee is requested to:

1. Consider and endorse the approach to Board level risk reporting, including:
   - closer alignment between the current Board Assurance Framework and the Avoidable Harm report; and
   - the proposed frequency for presentation of the full BAF/Corporate Risk Register to the Trust Board.

2. Endorse the updated Risk Management Policy for submission to the Trust Board for approval.

3. Receive assurance on the continued management and oversight of the Trust's principal risks including their review at the Executive Leadership Team and at relevant Committees.

4. Note:
   a. the changes to principal risk scores including the reduction in Risk 223 from 25 (5x5) to 20 (4x5) and risk 623 from 15 (3x5) to 10 (2x5)
   b. the work being undertaken to align Risks 160 and 558 into one overarching and holistic risk
   c. progress against the 2025/26 Risk Management Work Programme and support the proposed priorities for 2026/27, including the embedding of Risk Appetite, development of a strategic Board Assurance Framework and enhancement of risk reporting arrangements
   d. the suite of approved Risk Appetite Statements and endorse the next steps for their implementation, monitoring and assurance, as set out in the 2026/27 work programme.

ADDITIONAL PAPER(S)

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

The Trust Board is requested to receive the following:

Annex 1 Summary table describing the Trust's Principal Risks.
Annex 2 Scoring Matrix
Annex 3 Frequency of Risk Review
Annex 4 Board Assurance Framework (Ibabs Reading Room)
Annex 5 Principal Risk Trending Data
Annex 6 Risk Management Policy
Annex 7 Risk Management Reporting Schedule 2026/27

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
28 December 2025	Executive Leadership Team
20 January 2026	Finance & Performance Committee
29 January 2026	Trust Board
03 February 2026	Quality, Patient Experience & Safety Committee
10 February 2026	People & Culture Committee
02 March 2026	Audit, Risk & Assurance Committee

SITUATION

1. The purpose of the report is to provide the Committee with an update on the management of the Trust's principal risks and on progress against the risk management work programme, including activities to further strengthen the Trust's approach to risk management.

2. The report provides detailed information and assurance in relation to:

   - Risk Appetite
   - Electronic Risk Management System
   - Board level risk reporting and the Strategic Board Assurance Framework,
   - Risk Management Policy
   - 2025/26 Risk Management Internal Audit brief
   - Risk Trending Data and
   - 2026/27 Reporting Schedule

BACKGROUND

3. The Trust's Risk Management programme is overseen by the Audit, Risk & Assurance Committee (ARAC) and delivered through the Corporate Governance Directorate Plan.

4. The Trust's principal risks, as set out in this report, are allocated to Directors who are responsible for ongoing review and the delivery of agreed mitigating actions. In addition to directorate level reviews, formal risk review discussions are held by the Executive Leadership Team (ELT) focusing on risk escalation, changes in risk ratings, and the identification of new risks for inclusion on the Corporate Risk Register (CRR).

5. This report evidences the Trust's continued and sustained focus on effective risk management, demonstrated through regular review and challenge across multiple governance forums and through active oversight of planned mitigations across the system.

ASSESSMENT

Risk Appetite Statements

6. The Board approved the suite of 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.

7. 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.
8. 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.

9. 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.

10. The Risk Appetite Statements will be considered by the Trust Board in 6 months' time, which will be the 12 month point for annual review, once committee is content with the embedding principles and to consider several adjustments, for example, revisiting the appetite levels currently set and inclusion of other elements within the objectives.

11. The ARAC will oversee the next steps for the Risk Appetite Statements which will be included in the 2026/27 programme of work.

Risk Management Work Programme 2025/26

12. The outline programme of work includes:
    - June 2025: Repositioning Risks 223 and 224 (Complete)
    - July 2025: Anticipated appointment of a Risk Manager to the team (Complete)
    - July 2025: Electronic Risk Management system demos (Complete)
    - August / September 2025: Finalise Risk Appetite Statements (RAs) (Complete)
    - November 2025: Sign off Risk Appetite Statements by the Trust Board (Complete)
    - November/December 2025: New Electronic Risk Management System (Proof of Concept designed - Ongoing)

Risk Management Work Programme 2026/27

13. The scheduling for the 2026/27 work programme is being developed in March 2026 as part of the CorGov local delivery plan and includes the following:

    - Design and develop a strategic BAF aligned to the Trust's Strategic Objectives
    - Pilot a strategic risk against Strategic Objective 2 (work has already commenced on this)
    - Roll out a programme to develop a suite of strategic risks
    - Update the Risk Management Policy and guidance to reflect the Trust's approach to Risk Appetite
    - Design the next steps for risk appetite which includes:

- Development of a risk appetite dashboard, including tolerance and threshold frameworks and guidance and test how the Trust may use these for decision making.
- Development of a guideline on the use of risk appetite as an agreed action in the 2024/25 Internal Audit review to outline how this can be effectively employed as a key strategic tool and to enhance decision making by the Board.
- Designing risk appetite monitoring metrics and set up a reporting mechanism to monitor compliance against the risk appetite limits.

Electronic Risk Management System

14. The Trust has been actively progressing a new Enterprise Risk Management (ERM) system and explored systems on the market and opportunities to development an in-house system.

15. The contract for the current ERM system, Datix Web, ends in November 2027 across Wales, meaning the Trust must procure or develop an alternative system. The current system has significant technical and functional limitations and there is minimal support to implement system architecture changes required in line with our evolving risk processes, new legislation or organisational needs.

16. An early proof-of-concept has demonstrated strong potential for an in-house ERM platform that is bespoke, aligned to the Trust's governance framework. The proof-of-concept indicates that it is capable of integrating strategic and operational risks, automated reporting, and a digital BAF; functionality that has not been demonstrated by external suppliers to date.

17. This new in-house ERM system is being developed by the Head of Commercial and Assistant Direct of Corporate Governance and Risk. Detailed module designs and database specifications are drafted. An advantage of this in-house system is that it offers long-term commercial potential. Timelines for delivery of this work will be brought back to the next meeting.

18. The build of this new ERM 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 the new system has been implemented. However, ARAC will be aware from the 2024/25 risk management internal audit that the system is not widely or consistently used by directorates in WAST and is not used for the BAF.

Board Level Risk Reporting / Strategic Board Assurance Framework

19. The team is developing a refreshed strategic Board Assurance Framework (BAF), which will replace the current version once fully aligned to the updated strategic objectives. As this refreshed BAF matures, it will increasingly shape how harm-related risks and quality indicators are reported to the Board. Members agreed the format of the template for this BAF in February 2025.

20. Because the strategic BAF will incorporate strategic objectives, the way risks are framed and presented to the Board is expected to change. Nevertheless, risk reporting will remain proportionate, meaningful, and strategically aligned, providing assurance that each strategic objective is being effectively managed and delivered.

21. As an interim arrangement, and in collaboration with the Trust's auditors, the team is developing a revised approach to Board level risk reporting that more closely aligns the Trust's highest scoring risks with the evolving Avoidable Harm report.

22. The paper that the board receives at each meeting – Actions to Mitigate Avoidable Harm - will be expanded to include the current position and treatments for the two highest risks related to this - 223 and 224. It will also incorporate pathway specific harm indicators and new measures introduced in Phase 2 of the Ambulance Performance Framework including STEMI, stroke, and indicators of deterioration during long waits.

23. Strengthening the alignment between these reporting mechanisms will improve the Board's visibility of the most significant sources of avoidable harm, improve oversight, and provide clearer assurance. This will support the Board in identifying where organisational interventions could most effectively reduce risk within existing system constraints.

24. Given that the Trust's principal risks at reviewed in detail at each committee meeting, with assurance provided to the Board through Committee Chairs and the Alert, Assure, Advise (AAA) mechanism, it is proposed that the current full BAF/CRR is not presented at every Board meeting. This approach is intended to reduce duplication and ensure Board level assurance remains structured and adds value.

25. To support this approach, a high level dashboard summarising material changes to the Trust's principal risks could be appended to the AAA report from ARAC quarterly.

26. Members are therefore asked to discuss this proposal and consider the preferred reporting frequency for the full current BAF/CRR at Board meetings; for example, twice yearly, in line with arrangements adopted by several Health Boards.

27. The continued development of the refreshed strategic BAF will further shape how risks and harm related themes are presented to the Board. As the BAF is strengthened to align more closely with the Trust's strategic objectives, the structure and content of board level reporting will evolve accordingly to support a clearer, more strategic understanding of the interaction between patient safety, quality, and operational risks.

28. Planned work to refresh the long term strategy during 2026-27 will support an even closer alignment of the BAF to the strategic objectives.

Strategic Risks

29. During this quarter, work has commenced on articulating the first risk on the strategic BAF related to Strategic Objective 2 – 'enabling our people to be the best that they can be' and this will be presented at a future meeting. A suite of risks against each of the strategic objectives will be developed as the strategic BAF evolves.

30. The development of our new long-term strategy in 2026/27 presents and excellent opportunity to align our strategic BAF to this work at its inception.

Principal Risks

31. The ELT approved the principal risk activity on 28 December 2025 having considered the review of each risk undertaken throughout the period by Risk Owners.

32. 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.

33. 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.

34. 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.

35. The Trust's highest rated Risks 223 the Trust's inability to reach patients in the community causing patient harm and death and Risk 224 significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service, have been reviewed in the context of the Trust's strengthening internal control environment. These controls are underpinned by real-time clinical and operational oversight through the Operational Delivery Unit, the Clinical Safety Plan, and system-level escalation mechanisms such as REAP and national risk huddles.

36. Phase one and two of the Trust's Clinical Transformation Model have now gone live, with the new performance framework representing a significant milestone in delivering an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. In parallel, early adoption of the 45 minute release standard by some Health Boards represents a positive development, supporting more timely transfers of care and reducing avoidable harm.

37. Because of this progress, there has been a reduction in the score for Risk 223 from 25 (5x5) to 20 (4x5) which was discussed by the Board on 26 January 2026.

38. The ELT agreed that the score for Risk 224 will remain at 25 (5x5) for this round. Data will be kept under review for the next quarter with a view to reduce the score once an analysis has been completed to determine whether the recent changes have delivered sustained or system-wide risk reduction. Internal controls cannot fully mitigate external system constraints, including Emergency Department capacity, patient flow and inconsistent delivery of national handover standards.

39. While the Trust continues to demonstrate high levels of internal assurance, recent national focus on care standards and system performance provides an opportunity to strengthen consistency and improve the effectiveness of wider system responses. Historic variation in adherence to national handover standards and the delivery of improvement plans has limited the extent of risk mitigation achievable through internal controls alone. However, increasing national scrutiny, and a shift toward system-based accountability present an opportunity to deliver greater consistency and collective impact across organisational boundaries.

40. Strategic mitigation therefore remains focused on both internal transformation and system-wide influence. The Trust continues to engage 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. The Audit Wales report (June 2025) into the effectiveness of unscheduled care arrangements across NHS Wales provides external insight into whole-system performance and identifies further levers to drive national consistency and accountability.

41. The introduction of 45MR from 1 October 2025 was a partially accepted MAG recommendation. NHS Wales Performance and Improvement remains committed to this becoming the national standard, with Health Boards being required to adopt this by the end of January 2026. The progress already made by most Health Boards in the preceding months, represents a positive step toward reducing avoidable patient harm. A clinically led Handover-45 taskforce has been established, and workshops continue to support local improvement plans.

42. 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.

43. The risks continue to be reported to the Trust Board, with emphasis on actions within the Trust's control. These are reflected in the avoidable harm dashboard presented at each Board meeting. Further mitigations and transformational actions are also described in the Integrated Medium Term Plan (IMTP) and other regular reports, including the IMTP Assurance Report and the Monthly Integrated Quality & Performance Report to address these risks.

44. Most actions in the avoidable harm dashboard have been completed, and several efficiencies and improvements have contributed to stabilised performance. However, the Trust is cannot fully mitigate the scale of handover lost hours due to the wider system environment.

45. The Quality, Patient Experience and Safety Committee (QuEST) reviewed both risks at its meeting in February 2026 with the Agenda items reflecting the controls and mitigations discussed at this meeting. These risks continue to be escalated to the Board via the meeting's AAA report.

46. Work has continued, during this reporting period, on two stakeholder risks which have been disaggregated from **Risk 201** *A loss of stakeholder confidence that damages the Trust's reputation* to address the different aspects of reputation and ensure that the Trust's risks are accurately profiled. These are **Risk 201a** *Relationships with Stakeholders* and **201b** *Poor Patient Experience Affecting Reputation.* Both risks have been included on the Corporate Risk Register both at score of 16 (4x4) with a target score of 12 (3x4). The BAF extract for Risk 201 has not been included in the report before Committee today; however, the detail will be presented at the next meeting in June 2026.

47. **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 Committee today and has been considered by the private meeting of the Finance & Performance Committee (FPC) on 20 January 2026.

48. **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.

49. **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. There has been extensive work undertaken to better align this risk with **Risk 558** *Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures* to ensure it is more holistic, rather than separately focused on attendance and wellbeing. This new risk relates to deteriorating employee experience and workforce capacity due to underinvestment in people and organisational culture and looks at the resulting adverse impact on workforce capacity and patient safety. Whilst both risks remain in the BAF, it is intended that they will be superseded by this new risk which aligns its controls, gaps in controls, and actions against the three Cs of the People and Culture Plan, those being culture, capacity and capability.

50. **Risk 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* remains static at a score of 16 (4x4).

51. **Risk 671** *Unauthorised or Inappropriate use of AI technologies* remains static at a score of 16 (4x4) with a target of 8 (2x4). An AI Steering Group (AISG) has been established, reporting into Information Governance Steering Group, meeting for the first time in October 2025, to ensure the approach of "responsible AI" across the Trust.

52. **Risk 594** *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* remain unchanged this period and static at a score of 15 (3x5).

53. **Risk 623** *Failure to comply with Data Protection Legislation*, has achieved target score of 10 (2x5) reducing from 15 (3x5) and will be removed from the BAF. The risk is unlikely to ever be completely resolved as the landscape around the Trust constantly shifts and will be managed at a directorate level and by the Integrated Governance Steering Group.

54. **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.

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

56. **Risk 139** *Failure to Deliver our Statutory Financial Duties* remains unchanged at a score of 8 (2x4) during this period; however, this risk will continue to be considered in close detail in line with the financial position for 2026/27.

Risk Trending Data

57. A dashboard describing principal risk score trends from March 2023 and their movement over time has been produced and is attached at Annex 5. A heat map of these risks will be developed once work is completed to map these risks to the overarching strategic risks in development; those that will prevent the Trust from achieving its strategic objectives.

58. 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.

59. 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.

60. 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.

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

2025/26 Risk Management Internal Audit

62. The 2025/26 Risk Management Internal Audit is underway and will focus primarily on the ongoing development, implementation and application of the Trust's risk management and board assurance processes. A draft report is expected towards the end of February 2026 and will be presented to committee in May 2026.

Risk Management Policy

63. Members are asked to note that the Risk Management Policy has been updated to reflect the Board's position on risk appetite and its operationalisation through the BAF/CRR and committee structures. These amendments are reflected in sections 3.4 to 3.9. The amended policy is before committee today, at Annex 6, for endorsement and will be submitted to the March 2026 meeting of Trust Board for approval.

Risk Reporting Schedule 2026/27

64. The risk reporting schedule for 2026/27 is attached at Annex 7 which sets out the expected timetable for the reporting period.

RECOMMENDATION

65. The recommendations are as set out in the front cover above.

NEXT STEPS

66. A detailed review of each principal risk is underway with the outcome reported to the ELT on 04 March 2026 for discussion and approval of the activity.

67. The ARAC will oversee the next steps for the Risk Appetite Statements which will be included in the 2026/27 programme of work described in the report.

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	**20 (4x5)** ↓ **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	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there	Director of Digital Services	**20 (4x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	networks resulting in denial of service and loss of critical systems.	are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life		
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,	Director of Digital	**16 (4x4)**

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		equality, Welsh Language and ethical requirements **RESULTING IN** potential breach of confidentiality and data protection law, data, damage to Trust, and non-compliance with other legislation, regulation and standards.		
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)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Executive Director of Operations	**15 (3x5)** →
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	**10 (2x5)** ↓ **15 (3x5)**
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver	**IF** WAST fails to persuade JCC/Health Boards about WAST ambitions	Executive Director of Strategy Planning & Performance	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	appropriate levels of patient safety and experience.	**THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered		
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	**IF** the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained **THEN** there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised **RESULTING IN** a negative impact on colleague experience and/or services to patients.	Director of People & Culture	**12 (3x4)** ➡
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation.	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the	Executive Director of Finance & Corporate Resources	**8 (2x4)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage		

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	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.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Highly Unlikely: Will probably never happen/recur	**Not for years**	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	**At least annually**	2	4	6	8	10
3 Likely: It might happen/recur occasionally	**At least monthly**	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	**At least weekly**	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	**At least daily**	5	10	15	20	25

Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

RISK TRENDING DATA

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	Dec-25	Jan-25	Feb-26	Risk ID
			Period																	
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	20	20	20	260
	623	Failure to comply with Data Protection Legislation						15	15	15	15	15	15	15	15	15	10			623
	543	Major disruptive incident resulting in a loss of critical IT systems	15	15	15	15	15	10												543
	671	Unauthorised or inappropriate use of AI technologies												16	16	16	16	16	16	671
	620	Symptom Checkers									20	15	15	15	15	15	15	15	15	620
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	8	8	8	139
	542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan						16	16	16	16	16	16	16	16	16	16	16	16	542
	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													458
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	20	20	20	223
	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	15	15	15	594
	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	20	20	20	641
	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																245
	244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	12																	244
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					201
	201a	Relationships with Stakeholders														16	16	16	16	201a
	201b	Poor Patient Experience Affecting Reputation														16	16	16	16	201b
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	16	16	16	160
	163	Maintaining Effective & Strong Trade Union Partnerships	12	16	16	16	20	16	16	12	12	12	12	12	12	12	12	12	12	163
	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	15	15	15	558
	557	Potential impact on services as a result of Industrial Action	16	16																557
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	25	25	25	224
	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														199
	637	Diesel Fumes																		637
	538	Digital System Implementation			16															538
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	12	12	12	100
	424	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	12	16	16	16	16	12	8											424
	283	Failure to implement the EMS Operational Transformation Programme	12	12	12	12	12													283

Key (colour)	Meaning
Blue	Risk achieved target score and de-escalated to directorate level for ongoing monitoring
Pink	Risk closed from all registers
Yellow	Risk not in existence

Risk Management Policy

Policy Number:	107	**Version No:**	V2.1 (2026)	**Supersedes:**	V2.0 (25/09/2025)
Date of Approval:		**Review Date:**	Annually from date of approval	**Impact Assessments Completed:**	Yes
Classification of Document:	Corporate	**Type of Document:**	Policy	**Approved by:**	Trust Board
Brief Summary of Document:	The Risk Management Policy sets out the roles and responsibilities for risk management and the Board Assurance Framework				
Scope:	This Policy applies to all staff that are directly employed by WAST and encompasses Non-Executive Directors, bank staff, volunteers, contractors, and all those that it has legal responsibility for such as students and trainees.				
To be read in conjunction with:	Risk Management Guidelines (October 2023) Board Assurance Framework Guidance (April 2023)				
Owned By	Trust Board				
Policy Lead: **Trade Union Lead:**	Julie Boalch Hugh Parry	**Job Title:**	Assistant Director of Corporate Governance & Risk Trade Union Partner		
Director:	Trish Mills	**Job Title:**	Director of Corporate Governance / Board Secretary		

Version Control Sheet

Version	Date	Author	Summary of Changes
0.1	31/07/22	Julie Boalch	New Policy
0.2	08/09/22	Julie Boalch	Minor amendments following Policy Group discussion
0.3	08/01/23	Julie Boalch	Review and amendment of whole Policy following consultation period
0.4	10/01/23	Julie Boalch	Further redrafting based on comments received in consultation.
0.5	23/10/23	M Stoicheci	Review of sections
0.6	31/10/23	Julie Boalch	Prepare draft 2.5 for onward review and governance
0.7	17/11/23	Trish Mills	Review of sections
0.8	15/12/23	Julie Boalch	Formatting, enhancing three lines of defence model, risk appetite and statements section, the BAF section and adding Duty of Quality to introduction and BAF section. Updated auditing and monitoring section.
0.9	19/12/23	Julie Boalch	Front cover, who policy applies to, to be read in conjunction with, 3.4 included monitoring, treatment and acceptance of risk, updated 3rd line of defence definition
0.10	04/01/24	Julie Boalch	Minor update following Policy Group i.e. Trist instead of Trust. No material changes
0.11	13/02/24	Julie Boalch	Version control updated to reflect new policy. Section on strategic objectives strengthened to align to LTS.
0.12	21/02/24	Julie Boalch	Separated out the Risk reporting structure from the Roles and Responsibilities section 6. Created a new section 7.
0.13	18/03/24	Julie Boalch	Addition of volunteers to scope
1.0	28/03/24	Julie Boalch	Finalise front cover post approval at Trust Board and inclusion of University to WAST name and new logos
2.0	30/06/25	Lisa Trounce / Julie Boalch	No material changes other than updates to the name of the Audit, Risk & Assurance Committee and Director and Assistant Director of Corporate Governance titles.
2.1	15/02/26	Julie Boalch	Update to Risk Appetite sections 3.4 to 3.10

Version	Date	Author	Summary of Changes
Keywords	Risk, Risk Appetite, Risk Management, Risk Assessment		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
EqIA / Welsh Language	30/08/22	Julie Boalch, Melfyn Hughes, Hugh Parry
EqIA / Welsh Language	02/12/23	Julie Boalch, Hugh Parry, Kathryn Cobley

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	08/09/22	Review prior to consultation
Policy Group	23/01/23	Review post consultation
Policy Group	04/01/24	Review following further update
Trade Union Partners Team	TBC	Recommend for approval
Assistant Directors Leadership Team	TBC	Recommend for approval
Executive Leadership Team	TBC	Recommend for approval
Audit Committee	01/03/24	Recommend for approval
Trust Board	28/03/24	Approval
Policy Group	30/06/25	Recommend for approval
Assistant Directors Leadership Team	10/07/25	Recommend for approval
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Trust Board	25/09/25	Approved
Policy Group		
Audit, Risk & Assurance Committee		
Trust Board		

Disclaimer
If the review date of this document has passed, please ensure that the version you are using is the most up to date either by contacting the document author or by emailing AMB_Policies@wales.nhs.uk

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1. INTRODUCTION AND AIM

Risk is inherent in everything we do to deliver high quality services. Effective and meaningful risk management remains as important as ever in taking a balanced view to managing opportunity and risk (HM Government, Orange Book, 2020).

The Welsh Ambulance Services NHS University Trust (WAST) governing documents, the Standing Orders, set out the requirements that the Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Trust business, its governance, and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

The Trust is also guided by its legal responsibility outlined in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to ensure that there is an effective quality management system embedded across all areas of the Trust.

Risk is a vital component of this quality management system, and, in line with the Health and Care Quality standards 2023, the Trust has a responsibility to prioritise and implement a Risk Management Framework that enables the identification and monitoring of risks, and where possible, reduces or prevents risks to safety and ensuring it delivers a safe and high quality service.

The Trust is fully committed to fulfilling its obligations under the Duty of Quality by setting the highest standard of quality in everything it does, by embedding quality in its decision making and in managing the risks associated in the delivery of its services.

The purpose of this policy is to set out the roles and responsibilities for risk management and internal control at WAST and to maintain a robust risk management framework that ensures risks are effectively addressed.

It will:

- Set out the approach to risk management within the Risk Management Framework.
- Set out respective responsibilities for strategic and operational risk management for the Board and staff throughout the organisation.
- Ensure that risk management is an integral and positive part of the Trust's culture.
- Ensure that the Trust meets its legal obligations in respect of risk management.

- Minimise the impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment, and management.
- Maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively.

2. SCOPE

This Risk Management Policy applies to all staff that are directly employed by WAST and encompasses Non-Executive Directors, bank staff, volunteers and contractors and all those that it has legal responsibility for.

It is intended to cover all the potential risks that the organisation could be exposed to and must be read in conjunction with the Risk Management Guidelines (October 2023) Procedure and the Board Assurance Framework Guidance (April 2023) that have been produced as subordinate adjuncts to this Policy.

3. RISK MANAGEMENT

3.1. What is Risk Management

Risk Management improves performance, encourages innovation, and supports the achievement of the Trust strategic objectives.

It consists of a defined series of steps which help us understand risks and their impact. It is the process of assessment, analysis, and management taken to minimise the likelihood of a risk materialising and reducing the potential impact it may have if it does.

Good risk management awareness and practice at all levels is a critical success factor for the Trust and needs to be seen as integral in every function, service, and area.

3.2. Types of Risk

Strategic Risks are those risks that could impact upon the delivery of the Trust's strategic objectives as outlined in its long-term strategy, Delivering Excellence 2030, and which need to be raised and monitored by the Executive Leadership Team (ELT) and the Board.

Principal (Corporate) Risks are risks that are escalated to the Corporate Risk Register (CRR) from the Directorate Risk Register (DRR) dependent on scoring or whether they are cross directorate risks Plan and require a corporate response. These are reviewed and monitored by the Assistant Directors Leadership Team (ADLT), the ELT, Board Committees, and the Board.

Operational (Service and Directorate) Risks are key risks that could affect the quality, safety or delivery of services and are managed by individual Directorates and their local teams. If necessary, these can be escalated through the risk reporting structure for inclusion on the CRR.

Project risks are risks that could cause doubt about the ability to deliver a project on time, within budget and to quality. These are monitored and reported through the Project and Programme Boards.

3.3. Recording and Reporting

The purpose of risk recording and reporting is to enable the Trust to manage risk and mitigating actions as well as communicate risk management activities and outcomes across the organisation, provide information for decision making, meet governance requirements and support the Board in meeting its responsibilities.

It is important that risks are included on a register in order that they can be escalated if necessary and managed at higher level.

3.4. Risk Appetite

The Trust recognises, as a healthcare provider, that risk is inherent in delivering timely, safe and effective care to patients. Additionally, risk arises in enabling and empowering our people, managing finances and resources, and striving to remain a quality driven and innovative organisation.

Risk appetite is defined as the amount and type of risk that the Trust is willing to accept in pursuit of its strategic objectives. It provides a framework for balancing opportunity and innovation with the threats and uncertainties that are an inevitable part of delivering healthcare services.

The Board has approved a suite of seven Risk Appetite statements which form essential components of the Trust's risk management framework. These statements describe the level of risk that the Trust is willing to tolerate to achieve better outcomes for our patients, local communities as well as for our people and in working with our partners and stakeholders.

Each Risk Appetite statement has been developed and aligned to the Trust six strategic objectives as outlined in the Long Term Strategy: Delivering Excellence 2030.

3.5. Risk Appetite Levels

The Trust's risk appetite is articulated across five levels, which guide decision making and risk management in pursuit of its strategic objectives. The five levels are defined 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:** Willingness 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.

3.6. Application of Risk Appetite to Strategic Objectives

Details of the Trust's Risk Appetite Statements are included in Annex 1 of this Policy and will remain a standalone document.

The document describes the level of risk appetite associated with each of the six objectives. Strategic Objective six has been separated into two components to reflect differing levels of risk appetite:

SO6a relates to financial probity, performance, and sustainability, value-based healthcare, and value for money.

SO6b relates to commercial innovation, the foundation economy, and environmental sustainability.

3.7. Embedding Risk Appetite

The Trust will deliver this approach by considering the external and internal environments in which it operates in, fostering a positive and open risk culture, and maintaining a robust risk management framework to monitor, manage and mitigate risk.

This provides managers at all levels of the organisation with a clear framework within which to operate, supporting a risk-based approach to decision making that is aligned to the Trust's strategic objectives.

3.8. Accepting Risk

Decisions to accept risk may be influenced by the following considerations:

- The likelihood of occurrence is low and/or the potential consequences are insignificant.
- A higher level of risk is outweighed by the potential for significantly greater benefit where the risk is appropriately managed.
- The cost of mitigating the risk is disproportionate to the potential impact should the risk materialise.
- Treating the risk would introduce further unacceptable risks elsewhere.
- Accepting the risk is reasonable where all other options, including taking no action, present a greater level of risk.

3.9. Review of Risk Appetite Levels

The Board will set the Trust's Risk Appetite annually, or sooner if required by material change.

3.10. Board Assurance Framework

The Board Assurance Framework (BAF) is an integral part of the system of internal control and contains the strategic risks It summarises the controls and assurances that are in place, any gaps in these and the actions to mitigate them. The BAF provide a basis upon which the Board will identify, monitor, and evaluate risks which impact up its strategic objectives.

The BAF is a key source of evidence that links the Trust's strategic objectives to risk and assurance, and one of the tools that the Board will use in discharging its overall responsibility for internal control.

It will be developed through the following key steps:

- The Board agrees its strategic objectives, as set out in the Long Term Strategy, which are delivered through the Integrated Medium Term Plan (IMTP process) and aligned to the BAF.

- The ELT, with the support of the Head of Risk/Deputy Board Secretary, will identify the principal risks that may threaten the achievement of the Trust's objectives; these risks will then be discussed and approved by the Board.

- Once agreed by the ELT the completed BAF will be presented to the Trust Board for scrutiny and approval at all regular meetings.

The Trust is embarking on a maturity journey of the BAF which relies on risk appetite statements being aligned to it to inform decisions about its strategic direction and objectives and will have due regard for the requirements of the Duty of Quality.

3.11. The Trust's Strategic Objectives

The Trust's six strategic objectives as described in the long-term strategy are detailed below:

3.12. Risk Management Procedure

The full risk management process is articulated in the Risk Management Guidance (aligned to ISO31000) which supports this Risk Management Policy by explaining in detail how to manage risk in particular:

- Types of Risk (Strategic, Principal and Directorate)
- Risk Assessment
- Risk Identification
- Articulation of Risk (Title, summary description, controls, assurances, gaps, actions)
- Risk Analysis and Assessment
- Risk Treatment

- Monitoring and Review
- Recording and Reporting (Datix, BAF)
- Escalation/De-escalation of Risks
- Review of Risks
- Risk Scoring
- Risk Training
- Definitions

4. STATUTORY AND REGULATORY REQUIREMENTS

The Trust's governing documents, the Standing Orders, require the Trust to have a Risk Management Framework in place. The Chief Executive Officer, as Accountable Officer, has overall responsibility for ensuring that the Trust has an effective risk management framework and system of internal control; however, Directors have a responsibility for the ownership and management of principal and operational risks within their own portfolios.

This Policy is the overarching document for implementing the Risk Management requirements and is intended to meet all legal and internal requirements.

5. RISK MANAGEMENT ORGANISATIONAL STRUCTURE

5.1. The Three Lines of Defence in Effective Risk Management and Control

Apart from internal and external audit, the Trust has the freedom to decide on where it receives its assurance from. The Board, Audit, Risk & Assurance Committee (ARAC) and ELT will determine the source of assurance it needs and from a wide range of sources.

The three lines of defence model is a risk management framework that is designed to create a system of checks and balances, promote transparency, accountability, and ensure the Trust takes a structured and effective approach to risk management. By clearly setting responsibilities and oversight functions, this model will help the Trust to prevent and detect risks early.

Each line of defence has a distinct role in creating a positive environment for risk management and control across the Trust. The three lines are described below:

First line: This is operational management assurance where day to day operations take place.

Second line: This is where the oversight of management activity takes place and is separate from those responsible for delivery. It provides guidance, monitoring, and independent assessment of risk management processes but it is not independent of the Trust's management chain.

Third line: This relates to independent and external bodies that are separate and detached from the Trust that operate autonomously which ensures transparency, credibility, and impartiality. These are mandated and commissioned. The principal aim of this type of assurance activity, such as internal audit, Audit Wales, and Health Inspectorate Wales (HIW) is not only to assure the Board, but also to provide assurance to the public and other stakeholders.

Whilst there is a wide range of assurance activities within the Trust, in determining its programme of assurance, the Board will need to ensure that they are making the best use of the information they have available to them.

The table below describes the types of assurance the Trust will receive in each of the three lines of defence.

First line of defence	Second line of defence	Third line of defence
• Evidence of delegation of responsibility through line management arrangements • Compliance with PADRs • Compliance with policies, procedures, strategies, and frameworks • Incident reporting and thematic reviews • Performance reports • Finance reports • Compliance with risk management processes and systems	• Quality, Performance Management Framework • Strategic Transformation Board • Local Delivery Plans • Key metrics • Audit Tracker • Clinical audit • Speaking Up Safely Guardians • Risk management • Local counter fraud • Quality standards self-assessment • Pulse surveys • NIS Toolkit • Annual report • Equality impact assessments • Welsh language standards compliance	• NHS Staff satisfaction survey • Patient feedback • Audit Wales Structured Assessment • Auditing of accounts Trust and Charity • WG monitoring status. • Commissioned/peer review reports. • HIW inspection report • WG reviews • Regulator visits • Accreditation schemes • Llais • Various Commissioners • Public service ombudsman • HSE

	• Governance codes • PIRs • Systems of integrated governance	

6. ROLES AND RESPONSIBILITIES

The section below describes the respective risk management duties for individual staff members.

6.1. Chief Executive

The Chief Executive is the Accountable Officer of WAST and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, quality, financial and organisational controls, and governance.

The Chief Executive has overall accountability and responsibility for ensuring that the Trust maintains an up-to-date Risk Management and Board Assurance Framework that is endorsed by the Board.

In addition, the Chief Executive will:

- Ensure that there is a framework in place which provides assurance to the Board in relation to the management of risk and internal control.

- Ensure that risk issues are considered at each level of business planning from the corporate process to the setting of staff objectives.

- Have in place an effective system of risk management and internal control.

- Set out the Trust's commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974 and the National Health Service (Wales) Act 2006.

6.2. Director of Corporate Governance / Board Secretary

The Director of Corporate Governance is responsible for the effective management of, and compliance with, this Policy. This includes:

- Work closely with the Chair, Chief Executive, Chair of the Audit, Risk & Assurance Committee and Executive Directors to implement and maintain the Risk Management Policy and BAF and related processes, ensuring that effective governance systems are in place.

- Work with the Board to develop a shared understanding of the risks to the Trust's strategic objectives.

- Develop and communicate the Board's risk awareness, appetite, and tolerance.

- Lead and participate in risk management oversight at the highest level, covering all risks across the organisation, on a Trust basis.

- Work closely with the Chief Executive and Directors to support the development and maintenance of Corporate and Directorate level risk registers.

- Develop and oversee the effective execution of the BAF and ensure effective processes are embedded to rigorously manage the risks therein.

- Monitor the action plans and the processes for risk reporting to the Board and relevant Committees.

- Develop and implement the Trust's Risk Management Policy and BAF.

- Ensure the Policy is approved as part of the Governance framework by the Trust Board.

Ensure that the document is accessible to all relevant staff, cascaded appropriately across the Trust and is reviewed in a timely manner.

6.3. Directors

The Directors are responsible for the effective management of and compliance with this policy within their Directorate.

Each Director is accountable for the delivery of their area of responsibility and will therefore ensure that the systems, policies, and people are in place to manage, eliminate or transfer the key risks related to the Trust's strategic objectives.

Specifically, they will:

- Communicate to their directorate the Board's strategic objectives and ensure that directorate, service and individual objectives and risk reporting are aligned to these.
- Ensure that a forum for discussing risk and risk management is maintained within their area which will encourage integration of risk management.
- Co-ordinate risk management processes to encompass risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register.
- Ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading guidance contained in this document.
- Provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk.
- Assess and communicate the risk related training needs of their staff and ensure staff attend relevant mandatory and local training programmes.
- Ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting.
- Ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process.

Executive Directors are also responsible for ensuring that the BAF and the risk management reporting timetable are delivered to the Board.

6.4. Assistant Director of Corporate Governance & Risk and Risk Team

The Assistant Director of Corporate Governance & Risk will act as the Trust's operational gatekeeper with the responsibility for providing guidance, advice, and support for the process of risk management on behalf of the Trust.

The Risk Team are responsible for co-ordinating the Trust's operational and strategic risks, including the Corporate Risk Register and the BAF. The team has a remit to work with Executives and Managers to co-ordinate, integrate, oversee, and support the risk management agenda, ensuring that risk management principles are embedded across the Trust.

The team will also coordinate the Risk Management Internal Audit process.

On a quarterly basis they will receive from the ADLT risks for potential inclusion on the Corporate Risk Register, as well as updates on those risks already being managed on the Corporate Risk Register. The team also provides training and support for WASTs individuals and teams engaged in Risk Management.

6.5. Head of Service/ Service Managers/ Locality Managers/ Duty Operations Managers

Each Directorate operates within the First Line of Defence. They are responsible for risks within their areas of operation and providing assurance to the Executive Leadership Team on the operational management and any support required in relation to the management of risk.

The identification and management of risk requires the active engagement and involvement of staff at all levels. This First Line of Defence recognises that staff are best placed to understand the risks relevant to their areas of responsibility and that the identification and management of risk requires the active engagement and involvement of operational teams.

Therefore, staff must be supported and enabled to manage these risks, within a structured risk management framework, and Managers are expected to take an active lead to ensure that risk management is embedded into the way their service or team operates.

They will update existing risks, consider new risks for inclusion, and escalate any extreme risks, utilising, where required, specialist input from individuals/teams within the first line of defence. These are presented to the ADLT and ELT for review and decision respectively.

6.6. Line Managers

Managers must ensure that their staff understand and implement this Policy and supporting processes, ensuring that staff are provided with the education and training to enable them to do so, thus reducing the risk of misinterpretation.

In addition, ensuring that new members of staff that join the Trust are made aware of the policy process and associated documents at local induction, and how to access the Policy.

Managers must be fully conversant with the Trust's approach to risk management and governance. They will support the application of this Policy and its related processes and participate in the monitoring and auditing process.

6.7. All Staff

All members of staff are accountable for maintaining risk awareness, identifying, and reporting risks as appropriate to their line manager. More specifically they will:

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the Trust's business.

- Report all incidents/accidents and near misses and comply with the Trust's incident and near miss reporting procedures.

- Be responsible for attending mandatory and relevant education and training events.

- Participate in the risk management system, including the risk assessments within their area of work and the notification to their line manager of any perceived risk which may not have been assessed.

- Be aware of and comply with the Trust's Risk Management Policy, processes, and associated procedures.

6.8. Central Corporate Functions

Central Corporate Functions such as Corporate Governance, Patient Safety and Putting Things Right, Health and Safety, Capital Estates and Facilities, Finance Directorate, People Services Directorate, Occupational Health etc all operate within the First Line of Defence. They will assist clinicians and managers by providing risk related advice and support specific to their area of responsibility.

6.9. Local Counter Fraud Services.

The Trust's Local Counter Fraud Specialist (LCFS) provides assurance to the Audit Committee regarding risks relating to fraud and/or corruption. The Trust's Annual

Counter Fraud Work Plan, as agreed by the Audit Committee, identifies the arrangements for managing and mitigating risks because of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS and then reported to the Audit Committee as appropriate. The LCFS works with the Head of Risk/Deputy Board Secretary to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Finance Directorate and are then escalated through the Trust's escalation process.

6.10. Health and Safety Team

The Health and Safety Team will be responsible for providing advice where a risk is related to Health and Safety. These types of issues are closely linked with risk management and specialist Health & Safety advisers can assist with the conduct of specific and/or specialist assessments.

7. RISK MANAGEMENT REPORTING STRUCTURE

7.1. The Board

Executive Directors and Non-Executive Directors share responsibility for the success of WAST, including the effective management of risk, and compliance with relevant legislation. In relation to risk management, the Board is responsible for:

- Articulating the Strategic Objectives for the organisation.
- Protecting the reputation of the organisation.
- Providing leadership on the management of risk.
- Approving the risk appetite for the organisation.
- Ensuring the approach to risk management is consistently applied.
- Ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately.
- Reviewing the BAF (strategic risks) and the high scored corporate risks (scored 15 and above) at each meeting.
- Endorsing risk related disclosure documents.
- Approving the Risk Management Policy on an annual basis.

7.2. Audit, Risk & Assurance Committee

The Audit, Risk & Assurance Committee has a specific role in relation to reviewing the effectiveness of the Risk Management Policy and the Board Assurance Framework by reviewing the adequacy and effectiveness of:

- A system of internal control and risk management.

- All risk and control related disclosure statements (particularly the Annual Governance Statement), prior to endorsement by the Board.
- The structures, processes, and responsibilities for identifying and managing clinical and non-clinical risks facing the organisation.
- The Trust's Corporate Risk Register and the adequacy of the scrutiny of risks by assigned Committees.
- The underlying assurance processes that indicate the degree of achievement of strategic objectives
- the systems and processes for the identification, management, escalation, and monitoring of risks.
- BAF and the appropriateness of disclosure documents.

7.3. Board Committees

The Committees of the Board all have a role to play in ensuring effective risk management. They will, through the scrutiny inherent in their committee activity, provide onwards assurance to the Board in relation to their elements of the BAF.

They will:

- Receive and scrutinise corporate risks and provide onward assurance to the Board in relation to risks assigned to them for oversight and scrutiny.
- Receive updates on actions taken to mitigate the risks and provide feedback and challenge to risk owners on these and any further actions required.

7.4. Executive Leadership Team

The Executive Leadership Team undertake the following duties:

- Promote a culture within the Trust which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key risk management issues within the Trust.
- Ensure appropriate actions are applied to both clinical and non-clinical risks Trust wide.
- Enable risks which cannot be dealt with locally to be escalated, discussed, and prioritised.
- Ensure Directorate Risk Registers are appropriately rated and agreeing action plans to control them.
- Review the risks on the CRR to determine whether any of them will impact on the Trust's Strategic Objectives, and if so, adding the risk to the BAF.
- Review the BAF before presenting it to the Board.

- Advise the Board of exceptional risks to the Trust and any financial implications of these risks.
- Review and monitor the implementation of the Risk Management Policy.
- Ensure that all appropriate and relevant requirements are met to enable the Chief Executive to sign the Annual Governance Statement.
- Approve documentation relevant to the implementation of the Risk Management Policy.

These duties have the aim of providing assurance to the Board that there is an effective system of risk management across the organisation.

7.5. Assistant Directors Leadership Team

The Assistant Directors Leadership Team (ADLT) are responsible for risks within their areas of operation and providing assurance to the ELT on the operational management and any support required in relation to the management of risk.

The ADLT will review updates to existing risks, consider new risks for inclusion and escalate any extreme risks to the relevant Executive Director with responsibility for that risk and the ELT, utilising, where required, specialist input from the Risk Owner and individuals/teams. This framework is managed by the Risk Team for presentation by Directors throughout the governance structure.

7.6. Internal Auditors

Internal Auditors operate as the 3rd Line of Defence. Internal Audit Services, provided by NHS Wales Shared Services Partnership, through a risk-based programme of work, will provide the Trust with independent assurance in respect of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the standards of good practice contained within the NHS Internal Audit Manual. They will also review the effectiveness of risk management arrangements as part of their programme of audits and reviews, reporting findings to the Audit Committee as appropriate.

8. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EqIA) was carried out to ensure this policy maintained the Trust’s equality standards. The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010), Human Rights

and the Welsh Language. Evidence gathered by undertaking an initial screening has indicated that a full EqIA is not required.

9. TRAINING

The effectiveness of managing risk within the Trust relies upon the knowledge of staff, patients and public regarding risk identification and reporting.

It is important that all staff are aware of their responsibilities regarding risk management and the identification and management of risk must be a core competency of the personal appraisal and development review.

A range of training and education relating to risk management will be available aimed at the specific needs of staff members and will follow a tiered approach to enable personnel to meet their Risk Management responsibilities outlined in this policy.

Level One – Risk Management Awareness. This will be provided to all staff on induction, as part of Core Mandatory Training, and will be repeated on ESR every 2 years. The intended learning outcomes are to understand what risk is, what risk management is, how a risk is reported and how the organisation's risk culture operates.

Level Two – Practical Risk Management. This level of training is targeted for any employee undertaking risk management as part of their primary or secondary roles, and for Team Leaders/Managers/Departmental Heads. Line Managers and Directors have a specific role to play in identifying candidates for this training, ideally in prelude to assuming a risk facing role, but if not then as soon as practicable after taking up a role. Level Two training does not require repetition, though this does not mean that additional risk related training and education should not be identified through PADRs. This training will be in two parts:

- Part 1. To understand the risk management framework including the risk management policy, the associated procedures, the BAF, the corporate risk register, risk appetite, risk culture, and roles and responsibilities.

- Part 2. To understand the risk management process including context, risk versus issue and incidents. Risk assessment, risk tolerance, risk scoring, risk treatments, escalation, communication, monitoring, and review.

Level Three – Board Level Risk Management Awareness. This level of training is designed for Board Members. It will be provided on induction and, to meet governance requirements, it must be repeated every two years thereafter. Level Three training will be sourced by the Board Secretary and scheduled within the rhythm of board meetings.

The training aim is to provide Members with an understanding of the risk management framework, with specific emphasis on the operational risk management approach; the risk management policy; 'setting the tone' and risk culture; risk appetite; the CRR and the BAF.

Non-Specific Training and Support. It is recognised that, in addition to these three levels of specified training, there may emerge a need for non-specific risk management training and support. Where this is applicable the Risk team can discuss the training need and either signpost to external sources of training/education or provide a bespoke training event for individuals, directorates, or small groups.

Where required the education and training programmes can also be extended to our independent contractor colleagues to support their responsibilities in the management of risk and safety.

Risk management training or awareness will be provided to all staff and further details are included in the associated Risk Management and Board Assurance Framework Procedure.

All Managers must ensure:

- That all members of staff receive sufficient training to fulfil their individual duties, to ensure compliance with this policy, and to understand the importance of identifying and controlling risks.
- That adequate risk assessment training is given to appropriate members of staff in their specific duties as defined within the Risk Management and BAF Procedure.
- It is essential that risk assessments are completed by competent members of staff, who have sufficient experience of the working procedures and have received the appropriate training.

10. AUDIT AND MONITORING

There is a requirement of all staff to comply with the provisions of this Policy and, where requested, to demonstrate such compliance.

Monitoring, compliance, and the effective implementation of this Policy will be considered through the ADLT, ELT and from feedback from the Risk Owners and Executive Directors which will ultimately support the risk maturity of the Trust.

All Risk Leads/Heads of Service will regularly monitor to ensure that measures to control risks are being fully implemented and remain effective. This includes the regular and continual review of risk assessments and risk registers, in accordance with the frequency set out in the Risk Assessment Procedure.

The regular review of the CRR and BAF will be undertaken and reported to each meeting of the Trust Board.

Internal Audit will undertake an annual review of the Risk Management within the Trust as part of its annual audit plan.

Audit Wales will consider the effectiveness of the Trust's Risk Management Framework within its annual Structured Assessment.

This Policy will be formally reviewed every year, or sooner should there be any service or legislative changes that require an earlier review to be undertaken.

11. HELP AND SUPPORT

Risk Management support and guidance is available from the Risk Team within the Corporate Governance Directorate.

ANNEX 1 – RISK APPETITE STATEMENTS 2025/26

Strategic Objective	Appetite Level	Risk Appetite 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.

Draft RISK REPORTING SCHEDULE: Apr 26 - Mar 27

Quar	BAF circulated for updates	Deadline to return Risk updates on BAF	ELT		ARAC		Trust Board		FPC		QuEST		PCC			Charity Committee	
			Deadline for Papers	Meeting Date	Deadline for Papers	Meeting Date	Deadline for Papers	Meeting Date	Deadline for Papers	Meeting Date	Deadline for Papers	Meeting Date	Deadline for Papers	Meeting Date		Deadline for Papers	Meeting Date
1	26/02/2026	23/03/2026	01/04/2026	08/04/2026	19/04/2026	28/04/2026	19/05/2026	28/05/2026	05/05/2026	19/05/2026	28/04/2026	07/05/2026	26/04/2026	05/05/2026		24/03/2026	02/04/2026
2	09/05/2026	11/05/2026	20/05/2026	27/05/2026	14/06/2026	23/06/2026	N/A	N/A	N/A		N/A	N/A	N/A	N/A		N/A	N/A
3	07/06/2026	22/06/2026	01/07/2026	08/07/2026	25/08/2026	03/09/2026	21/07/2026	30/07/2026	10/07/2026	21/07/2026	28/07/2026	06/08/2026	31/07/2026	11/08/2026		26/06/2026	07/07/2026
4	11/07/2026	10/08/2026	19/08/2026	26/08/2026	N/A	N/A	15/09/2026	24/09/2026	04/09/2026	15/09/2026	N/A	N/A	N/A	N/A		22/09/2026	01/10/2026
5	20/09/2026	12/10/2026	21/10/2026	28/10/2026	24/11/2026	03/12/2026	17/11/2026	26/11/2026	06/11/2026	17/11/2026	27/10/2026	05/11/2026	30/10/2026	10/11/2026		N/A	N/A
6	29/11/2026	21/12/2026	30/12/2026	06/01/2027	N/A	N/A	19/01/2027	28/01/2027	08/01/2027	19/01/2027	26/01/2027	04/02/2027	29/01/2027	09/02/2027		05/01/2027	14/01/2027
7	16/01/2027	25/01/2027	03/02/2027	10/02/2027	23/02/2027	04/03/2027	16/03/2027	25/03/2027	05/03/2027	16/03/2027	N/A	N/A	N/A	N/A		N/A	N/A

	Trust Board & Corporate Trustee	FPC	QuEST	PCC	Charity Committee
	28-May-26	19-May-26	07-May-26	05-May-26	02-Apr-26
AGM	**30-Jul-26**	21-Jul-26	06-Aug-26	11-Aug-26	07-Jul-26
TB	**24-Sep-26**	15-Sep-26	05-Nov-26	10-Nov-26	01-Oct-26
	26-Nov-26	17-Nov-26	04-Feb-27	09-Feb-27	14-Jan-27
	28-Jan-27	19-Jan-27			
TB	**25-Mar-27**	16-Mar-27			

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

Agenda Item No.	09.1

REPORT TITLE

2025/26 Annual Accounts Update

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	02 March 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This report provides the Committee an update on planning undertaken, progress made and any issues arising with both the preparation and external audit of the 2025/26 Annual Accounts.

Key highlights for the Committee to note are as follows: -

2. At the time of writing, Welsh Government (WG) are yet to provide the final year-end timetable, but the draft year-end timetable proposes audit certification deadline of 30 June 2026 which is in line with the certification date for 2024/25.

3. The below key dates are based on the draft timetable issued by WG. The final timetable is not anticipated to be significantly different:

Key Dates			
ELT to review draft Remuneration Report by Email	Wednesday	29 April 2026	
Submit Unaudited accounts, Pooled Budgets and All FRs including FR6,(except FR10) MS A to C and F-H inclusive	Friday	01 May 2026	(noon)
Audit commences	Tuesday	05 May 2026	
WG to issue Debtor & creditor matrix Income and expenditure matrix	Wednesday	06 May 2026	
NHS Bodies to submit Accountability Report (Statement of Accountable Officer Responsibilities, Statement of Directors responsibilities in respect of the accounts, Annual Governance Statement) (At this stage the statements are not signed and the AGS is in draft).	Friday	08 May 2026	(noon)
NHS Bodies to submit (from Finance) Remuneration Report TMS2 and FR10	Friday	08 May 2026	(noon)
Closure meeting with External Auditors	Wednesday	10 June 2026	PROV
Audit, Risk & Assurance Committee meeting initial accounts approval	Tuesday	23 June 2026	
Trust Board meeting to formally approve and sign accounts	Thursday	25 June 2026	
Audit Wales to submit final audited accounts to the Welsh Government including:- Audited accounts All TFRs TMS 1 A to C and F-H inclusive Audited accounts, Annual Report Sections including; Accountability Report (Statement of Accountable Officer Responsibilities, Statement of Directors responsibilities in respect of the accounts AGW Report and Certificate, Performance Report, Annual Governance Statement, Remuneration Report) and Financial Statements (audited accounts)	Tuesday	30 June 2026	(noon)

4. AW has been carrying out interim audit work during February which includes early planning, systems and testing work. It is planned that the AW team will continue working on this area during March and April, bringing any queries back to the WAST Finance team in May.

5. AW have provided the draft Outline Audit Plan for 2026 and have advised that the Detailed Audit Plan for 2026 will be provided in readiness for the April ARAC meeting.

6. AW have recently sent to us the '*Audit enquiries of those charged with governance and management letter for 2025/26*' for completion by 10th April (certain elements cannot technically be completed until after 31 March 2026). The Trust's planned response to this will require consideration and approval by Committee members, therefore this will be circulated later.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to note the contents of this report.

ADDITIONAL PAPER(S)

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

N/A

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
N/A

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
N/A	N/A

Agenda Item No.	09.2

REPORT TITLE

2025-26 Annual Filings Schedule

MEETING

Name of meeting	Audit Risk and Assurance Committee
Date of meeting	02 March 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Lisa Trounce, Head of Compliance and Assurance

PURPOSE OF REPORT

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

EXECUTIVE SUMMARY:

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

1. The Annual Filings **Task and Finish Group** ("the group") was re-established in November 2025 to ensure that the Trust meets the Annual Report and Accounts 2025-26 disclosure and reporting requirements as set out in the draft Manual for Accounts (MfA) published by Welsh Government (WG).

2. The Task and Finish Group **terms of reference** were approved by the Executive Leadership Team (ELT) on 18 February 2026 and the expected submission dates noted.

3. The Trust Annual Report includes the **Performance Report (Part 1)** and the **Accountability Report (Part 2)**. The MfA indicates that the overarching structure of the Annual Report for 2025-26 has not changed; however, the final MfA is yet to be received.

4. The Trust is also required to prepare and publish a **Duty of Quality Annual Report**. To avoid duplication, and in an attempt to reduce the size of the Performance Report (Part 1), discussions are taking place to identify ways in which data can be reported more effectively via these two reports.

5. The proposed **timetable** for development, approval and reporting of the Annual Report [**Annex 1**] was shared with the ELT at its weekly huddle on Monday 23 February 2026. The timetable has been drafted based on the draft MfA, therefore it is subject to change as the final MfA is yet to be received. The deadline/certification date for the 2025-26 filing is the 30 June 2026. The Finance Team will maintain a work programme for the production of the accounts.

Next Steps

6. Pending committee approval of the proposed timetable, **commissioning** of the Annual Report (Parts 1 and 2) will commence and continue throughout March 2026.

7. Following review by ELT and completion of final edits, at the end of April 2026, the draft Annual Report will be circulated to **committee members for awareness and comments**.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Audit, Risk and Assurance Committee is requested to:

1. **Approve** the proposed 2025-26 Annual Filings Timetable;
2. **Receive Assurance** from the planned approach; and
3. **Note** the planned next steps.

ADDITIONAL PAPER(S)

Annex 1 2025-26 Annual Filings Timetable

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
17 February 2026	Director of Corporate Governance/Board Secretary
23 February 2026	Executive Leadership Team (ELT)

2025/26 DRAFT ANNUAL FILINGS TIMETABLE

HIGH LEVEL DEADLINES	ACTION	DETAIL	EXECUTIVE LEAD
01/05/2026 [Confirmed]	Submission Deadline	Draft 25/26 Unaudited Accounts	Chris Turley
08/05/2026 [Confirmed]	Submission Deadline	Draft Annual Report	Trish Mills
30/06/2026 [Confirmed]	Submission Deadline	Final Annual Report & Accounts to Audit Wales	Chris/Trish

DEADLINE	ACTION	DETAIL	EXECUTIVE LEAD
13/02/2026	DL for ELT Paper	DL for submission of paper for ELT	Trish Mills
18/02/2026	ELT Meeting Date	Paper received with filings schedule	Trish Mills
20/02/2026	DL for AC Paper	DL for submission of paper for ARAC on 02/03/2026	Trish Mills
02/03/2026	**Audit, Risk and Assurance Committee Meeting**	Receipt of paper at ARAC setting out the annual filings timetable for approval	Trish Mills
03/03/2026-13/03/2026	Commissioning of AR/PR	Review of narrative ownership and commissioning	Trish Mills
03/03/2026-31/03/2026	**DRAFTING**	Drafting of Annual Report by stakeholders	Trish Mills
01/04/2026	Submission to Corporate Gov Team	Submission of draft narrative of the AR/PR	Trish Mills
08/04/2026	Submission to Board Secretary for Review	Annual Report - for review by Board Secretary no later than the 08/04/2026	Trish Mills
23/04/2026	DL for ELT paper - Draft AR	Draft AR to ELT for receipt / comment	Trish Mills
24/04/2026	Email circulation to ELT	Circulate to ELT for remote comment, then to be received at ELT on 29/04/2026	Trish Mills
24/04-28/04/2026	Review of AR/PR	Review of AR/PR by RM/TM/HB/AP & Final Edits	Trish Mills
29/04/2026	**ELT Meeting**	Receipt of draft AR	Trish Mills
29/04/2026	**Email Circulation**	Draft RemReport to RemCom	Trish Mills
29/04/2026	**Email Circulation**	Draft AR to AC for awareness and comment	Trish Mills
29/04/2026	**Email Circulation**	Draft ARA to Board - for awareness	Trish Mills
01/05/2026	**Submission Deadline**	Draft Unaudited Accounts to WG/Audit Wales	Chris Turley
06/05/2026 (18:00)	DL for comments by Audit Com.	DL for responses by Audit, Risk and Assurance Committee	Trish Mills
06/05-07/05/2026	Final Review / Updates of Draft ARA	Final draft/review, ahead of submission on the 08/05/2026	Trish Mills
08/05/2026 (by 12:00)	**Submission Deadline**	Draft Annual Report to WG/Audit Wales	Trish Mills
08/05/2026 (>12:00)	**Submit ARA for Translation**	Submit to in house translation	Trish Mills
05/06/2026	DL for papers for ELT	DL for papers for ELT	Trish Mills
10/06/2026	Submission of final AR to ELT	Final 25/26 ARA submitted to ELT (potential receipt via email)	Chris/Trish
12/06/2026	Submission DL	Final 26/26 ARA submitted for Audit Committee	Chris/Trish
23/06/2026	**Meeting of Audit, Risk and Assurance Committee**	Audit Committee to scrutinise/endorse final 25/26 ARA [1 hour]	Chris/Trish
16/06/2026	Submission DL	Final ARA Submitted for Trust Board	Chris/Trish
17/07/2026	Submission DL for AGM		Trish Mills
25/06/2026	**Meeting of Trust Board**	Trust Board - Approval/sign-off of audited ARA [30 mins]	Chris/Trish
30/06/2026	**Submission DL**	**AUDIT WALES TO SUBMIT FINAL AUDITED ARA**	Chris/Trish
30/07/2026	**Annual General Meeting**	Presentation of the 25/26 ARA	Trish Mills

Agenda Item No.	10

REPORT TITLE

Integrated Governance Programme:
The Dynamic Integrated System of Governance and Oversight

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	02 March 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance / Board Secretary
Author(s) of report	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. The purpose of this paper is to provide an update to the Audit, Risk and Assurance Committee (ARAC) on the 2025/26 Integrated Governance Programme and deliverables.

2. The Trust commenced an ambitious integrated governance programme in 2024/25 aimed at enhancing governance structures throughout the organisation which aim to streamline and unify the mechanics and dynamics of governance.

3. The deliverables included in the 2025/26 work programme are summarised below and described in more detail in Annex 1 of the report.

    a. Quarter 1: Develop a new board, committee, organisational governance front cover and SBARN template; develop writing and presentation guidance to accompany this; and develop a LMS365 or cameo PowerPoint on AAA preparation and the use of new front covers. This is complete.

    b. Quarter 2: Meeting etiquette guidance and house style minutes. These documents are complete with an expected publication date of February 2026. The new style of minutes has already been adopted, for board and committees, utilising the new template.

    c. Quarter 3: Accountability, assurance and governance handbook. Work has commenced and an outline of the contents was presented to and endorsed by committee in September 2025. Work has paused due to capacity constraints in the team; however, engagement with key groups will commence to support delivery of the handbook in Q2 2026/27.

    d. Quarter 4: AI for governance. The use of CoPilot is encouraged for minute taking and the production of AAAs with prompts incorporated into the minutes guidance. Discussions are underway with the digital team and feature at the AI Steering Group to manage a secure platform within the Trust and which will bring several efficiency gains.

4. Additional work has been undertaken, alongside the agreed deliverables, to further enhance the integrated governance programme; including:

    a. Style Guide. This was published in September 2025; however, this will be reviewed against the recently published Welsh Government guidance.

    b. SBARN and AAA templates. Minor edits will be incorporated to be able to reflect local forum reporting at tiers 2 and 3. A Siren notice will be issued to highlight the changes.

c. Executive Summary Quick Read Guide. This is in development to support authors to produce a high level summary aligned to board and committee remits.

5. Work on the accountability, assurance and governance handbook will be advanced in Q1 and Q2 2026/27 alongside a review of the internal governance structures that report into the Executive Leadership Team. A further update will be provided to this Committee at that time.

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 progress of the integrated governance programme and the 2025/26 deliverables.

2. Note additional pieces of work that have been developed to further enhance the programme.

ADDITIONAL PAPER(S)

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

The Audit, Risk and Assurance Committee is requested to receive the following:

Annex 1 Integrated Governance Programme Deliverables

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
N/A

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document here for further details.	
Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
	N/A

Annex 1- 2025/26 Integrated Governance Programme

Deliverable	Desired Outcomes	Progress
Quarter 1 Develop a new board, committee, organisational governance front cover and SBAR template. Develop writing and presentation guidance to accompany this. LMS365 on AAA preparation	➢ Unified presentations across all forums aligned to our strategic objectives and duty of quality, setting a consistent tone and focus. ➢ Writing guidance will ensure that materials are developed with a clear understanding of what needs to be emphasised, particularly in executive summaries and then how to present those pertinent points. ➢ Clarity on impact assessments required to make decisions will promote better compliance with regulatory requirements and mitigate adverse impacts. ➢ Setting word counts and formatting makes the document easier to read and more accessible. This standardisation aids in reducing information overload and ensures key points are communicated effectively.	➢ Front covers (SBARN templates) and writing guidance developed ➢ Feedback on both received from NEDs 27 February 2025 ➢ Consultation 23 June 2025 until 11 July 2025 ➢ Documents shared with the ADLT and ELT August 2025 ➢ Implementation plan finalised and commenced ➢ New templates rolled out 13 August 2025. ➢ AAA guidance published on LMS365
Quarter 2 Develop meeting etiquette guidance to include: - Scheduling and invitations - Professional conduct - Recording and Documentatio n - Chat and camera functions - Meeting management - Follow-up and documentatio n	➢ The development of meeting etiquette guidance will enhance the efficiency and inclusivity of our organisational interactions. ➢ By establishing clear protocols for scheduling and invitations, we ensure that meetings are planned with consideration for all participants' schedules and commitments. ➢ Guidelines on professional conduct will foster a respectful and collaborative atmosphere, essential for productive discussions. ➢ Recording and documentation procedures will guarantee that valuable insights and decisions are captured accurately and are easily accessible for future reference. ➢ Effective meeting management will streamline discussions, ensuring they are focused and time efficient. Additionally, follow-up procedures will confirm that action items and responsibilities are clearly communicated and tracked post-meeting.	➢ Meeting etiquette guidance developed ready for publication in February 2026 ➢ Information Governance Steering Group reviewing the issues of retention of meeting recordings ➢ Minutes house style developed and ready for publication in February 2026 ➢ High level feedback received from NEDs ➢ The new style of minutes has already been adopted, for board and committees, utilising the new template

Deliverable	Desired Outcomes	Progress
- Access (languages, subtitles) Develop minutes house style	➢ Incorporating access features such as multiple languages and subtitles will make meetings more inclusive, enabling full participation from all members regardless of language barriers, thus enriching collaboration and enhancing overall communication within WAST. ➢ A 'minutes house style' for board and committees, as well as guidance for other tiers in the organisation provides consistency, clarity and accessibility, efficiency, improved accountability and better storage and search functionality.	
Quarter 3 Accountability, assurance and governance handbook	➢ The Integrated Governance Handbook complements the integrated governance mapping, providing clear and effective principles for our governance, accountability, risk, and assurance frameworks. ➢ The handbook outlines our organisational policies, from standing orders to board dynamics, while fostering a culture of autonomy, belonging, and contribution. It aligns all governance activities from floor to board, clarifies the nature and application of assurance, upholds transparency, and encourages continuous improvement. ➢ Enhanced by a variety of helpful annexes, the handbook offers vital educational and training resources to bolster governance capabilities at all levels.	➢ Draft commenced ➢ High level outline of contents considered by ARAC in September 2025 ➢ Draft document was due to be presented at ARAC in March 2026; however, this work is paused due to capacity constraints in the team ➢ Engagement with key groups will commence Q1 2026/27 ➢ Delivery expected in Q2 2026/27
Quarter 4 AI for governance	➢ AI, managed within a secure platform at WAST, will bring a number of efficiency gains. With the initial roll out aimed at usual meeting artifacts such as minutes, AAA reports and actions and decisions. ➢ Future rollouts could include how to use AI in writing, analysis and presentation of key points. ➢ Dependency: Enterprise AI (Co-pilot) being rolled out more widely at WAST. Currently Co-pilot is limited to a few and Chat GPT is not yet secure enough to use widely.	➢ Already in use for several forums ➢ 'Promptathons' taking place for use for minutes and production of AAAs ➢ Outcomes to be incorporated into minutes and writing guidance ➢ Dependency: Enterprise AI CoPilot being rolled out more widely at WAST.

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

Agenda Item No.	11

REPORT TITLE

Audit Tracker 2025-26 Q3 Reporting (Oct-Dec25)

MEETING

Name of meeting	Audit Risk and Assurance Committee
Date of meeting	02 March 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Lisa Trounce, Head of Compliance and Assurance

PURPOSE OF REPORT

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

EXECUTIVE SUMMARY:

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

1. The purpose of this report is to provide the Audit, Risk and Assurance Committee (ARAC) with an overview of progress against internal and external management actions during 2025/26 Quarter 3, together with assurance regarding governance arrangements supporting delivery and oversight.

2. Committees have reviewed actions within their respective remits and have reported through their Assurance, Advice and Alert (AAA) reports. No matters have been escalated to the Board.

Internal Audit Actions (Overall)

3. During 2025/26 Quarter 3, there were 77 open internal audit actions overall**,** of which 35 were due for completion within the quarter.

- 24 actions (69%) were closed in Quarter 3, including:
  - 21 completed within the quarter
  - 1 completed ahead of schedule
  - 2 historical actions closed by agreement as no longer applicable

4. While marginally below the Quarter 2 closure rate (71%), there has been a marked improvement in delivery against original deadlines:

- 77% of actions closed in Quarter 2 were achieved by their original agreed date (compared to 45% in Quarter 2, and 70% in Quarter 1)

This trajectory suggests that directorates are setting more realistic and deliverable target dates at the point management actions are agreed.

5. In terms of forward profile and delivery confidence, of the 55 actions remaining which remain open at the end of 2025/26 Quarter 3:

- 72% are scheduled for completion across Quarter 4 2025/26 and Quarter 1 2026/27 (between January – June 2026)

Directorates have confirmed commitment to these timelines. Whilst delivery coincides with major organisational programmes and seasonal pressures, the current trajectory indicates that completion remains achievable, subject to continued oversight.

6. Action with Revised Dates: During Quarter 3, a total of sixteen (21%) open audit actions were assigned revised dates, and five actions were given final revised deadlines.

7. Those with final revised deadlines are:

- ICT Contract Management (Ref 691) – arising from the 2023/24 internal audit. The action requires consistent application of contract management processes across all ICT contracts. The revised completion date has been extended to September 2026 due to workload pressures associated with contract renewals and resource capacity.

- Exposure to Fumes (Ref 040-24/25) – dependency on Digital Directorate capacity to automate data capture into the data vault. Completion is now scheduled for May 2026.

- Vehicle Accident Management (Refs 053-24/25 and 054-24/25) – relating to investigation guidance and documentation of post-investigation driver training. Revised dates (April–July 2026) reflect the need for testing, Trust-wide implementation, and collation of evidence prior to closure.

Responsible Directors of Digital, Operations, and Quality, Patient Safety and Experience, have been requested to attend Committee to provide assurance that revised timelines are credible and that mitigating controls are operating effectively pending completion.

Internal Audit Actions (ARAC specific)

8. There were no internal audit actions under the purview of this committee during Quarter 3.

External Audit Actions (Overall)

9. During Quarter 3, there were 35 open external audit actions relating to:

   - Audit Wales – Quality Governance Follow Up Review (2023/24)
   - Welsh Risk Pool – Concerns Assessment 2024
   - Audit Wales – Unscheduled Emergency Care (UEC) Review (reported 2025/26)

   Of the 12 actions due in Quarter 3 eight actions (67%) were closed, including one completed ahead of schedule. This represents a significant improvement compared to Quarter 2 (29%) and Quarter 1 (45%).

10. The *Quality Governance Follow-Up Review* showed reasonable progress, with four actions closed in quarter (two by original deadlines, and two by 1st revised dates). These were reviewed by the Quality, Patient Experience and Safety Committee in February 2026.

11. By way of update regarding the *Welsh Risk Pool - Concerns Assessment 2024*:

    - 28 recommendations in total.
    - 5 actions closed in Quarter 3.
    - 4 actions due in Quarter 3 remain open with revised deadlines (March and September 2026).
    - 4 actions are currently without completion dates, pending clarification of digital dependencies.
    - The remaining 26 actions are scheduled for completion by 31 March 2026.

External Audit Actions (ARAC specific)

12. There were no external audit actions under direct ARAC purview during the quarter.

Management of the Audit Tracker

13. Audit Tracker 3.0 has not been embedded across directorates. Quarter 3 represents the first full reporting cycle using the upgraded system. Key developments include:

- Expanded visibility to Responsible Officers.
- Automated email notifications three months prior to deadlines.
- Ongoing development of reporting dashboards supported by Power BI.

14. The transition has been stable, with only minor refinements required. Quarter 4 reporting will be presented via a Power BI dashboard accompanied by a focussed Executive Summary.

Overall Assurance Position

15. The Quarter 3 position demonstrates:

- Sustained improvement in completion against original deadlines.
- Stronger trajectory in both internal and external audit closure rates.
- Realistic forward planning across Quarter 4 and Quarter 1 delivery.
- Active oversight of actions with revised dates.
- Improved governance infrastructure through Audit Tracker 3.0.

Whilst capacity pressures and programme dependencies remain live risks, there are no matters currently requiring escalation to Board.

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 3;
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; and
3. Consider whether any further assurance is required in advance of the Quarter 4 position.

ADDITIONAL PAPER(S)

Audit Tracker 3.0 2025/26 Q3 (October – December 2025) – ARAC 020326 [in Ibabs reading room*]

Annex 1 Internal Audit ~ Full Audit Tracker (with actions shared in private session removed)
Annex 2 External Audit ~ Tracker filtered to show ARAC Audit Recommendations 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 & 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	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
03 February 2026	Quality, Patient Experience and Safety Committee
10 February 2026	People and Culture Committee
17 March 2026	Finance and Performance Committee [scheduled]
23 February 2026	Director of Corporate Governance/Board Secretary
02 March 2026	Audit Risk and Assurance Committee - Public

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.

   - 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 have recently reviewed updates against audit actions under their purview. 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 1 in reading room**)

5. During Quarter 3 there were a total of 77 open audit actions overall on Audit Tracker 3.0, with 35 of these due for closure in quarter.

6. Of these 35 actions due for closure in quarter, 21 actions (60%) due for completion were closed, alongside one action completed ahead of schedule. There were also two historical actions which were deemed to no longer be relevant and subsequently closed by agreement. This results in a total of 24 closures in total (69%) – just slightly below the 71% closure rate reported in Quarter 2.

7. The table below provides a breakdown of the total 22 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	2	0	1	1	0
2024/25	12	10	2	0	0
2025/26	7	7	0	0	0
Totals	**22**	**17**	**3**	**2**	**0**
% of Total Closed in Quarter		**77%**	**14%**	**9%**	**0%**

8. This is a significant improvement in the percentage of audit actions completed by their original deadline (70% for Q1, compared to 45% for Q2, and 77% for Q3). The fact that more actions are being closed by their original deadline in-quarter indicates realistic dates are being set when management actions are agreed.

9. As shown in the table below, 40 of the remaining 55 open internal audit actions, which equates to 72%, are scheduled to be completed during 2025/26 Quarter 4 and 2026/27 Quarter 1 (between January 2026 and June 2026).

Year	Total No. of Remaining Open Actions (Q3)	Due for Closure During FY & Quarter				
		2025/26	2026/27			
		Q4	Q1	Q2	Q3	Q4
2022/23	1	1	0	0	0	0
2023/24	5	0	4	1	0	0
2024/25	28	14	4	6	5	0
2025/26	20	11	6	2	0	1
Totals	**55**	**26**	**14**	**9**	**5**	**1**
% of Total Open Actions		**47%**	**25%**	**16%**	**9%**	**2%**

10. The projected closure rate for audit actions due in Quarter 4 (47%) and Quarter 1 (25%), 72% 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 and seasonal pressures. While these factors may require continued close oversight, current trajectories indicate that delivery remains achievable to ensure mitigations are in place.

Actions with Revised Dates

11. At the meeting in December 2025, this committee was informed of seven open audit actions which had been assigned final revised dates during Quarter 2. Of these, one action (Action Ref: 656a ~ Records Management) which was awaiting an amended deadline, has been closed in quarter.

12. Of the remaining six audit actions for which final revised dates were assigned during the previous quarter: two are scheduled for closure in Quarter 4 (January-March 2026), and four in the first two quarters of 2026/27 (one in Quarter 1 by the end of June 2026, and three in Quarter 2 by the end of September 2026).

13. Of the 77 open internal audit actions updated during Quarter 3, following review, a total of 16 (21%) have been assigned **revised dates in quarter**, this is an increase from that reported in Quarter 2 as shown in the table below:

	2025/26			2026/27		
	Q2	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
% Open Actions with New Revised Dates Applied in Quarter	29%	28% ↓	22% ↓	22% →	15% ↓	21% ↑

14. Of these 16, there are five open internal audit actions that have been assigned final revised dates this quarter, as shown in the table below.

Year	Audit Action Ref.	Priority Level Action	Internal Audit Title	Directorate	Original Deadline	Revised / Final Deadline
2022/23	621b	Medium	Technical Resilience	(Reported in private meeting)		
2023/24	691	Medium	ICT Contract Mngt	Digital	Mar-25	**Sep-26**
2024/25	040-24/25	Medium	Exposure to Fumes	Quality	Mar-25	**May-26**
	053-24/25	Medium	Vehicle Accident Management	Operations	Sep-25	**Jul-26**
	054-24/25	Medium		Operations	Sep-25	**Apr-26**

15. 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:

15.1 The 2022/23 audit action 621b is reported in the private meeting of this committee.

15.2 **Audit action 691 from the 2023/24 internal audit on ICT Contract Management** relates to ensuring that an ICT contract management process is applied to all ICT related contracts, with the ICT Contract Manager feeding into any management meetings within other directorates. The Contract Management (SOP) process was to be applied to all contracts listed on the contracts register. Recognising that this is a challenge given the volume of other work involved in concluding ongoing contract renewals and finalisation, potential additional resources were being considered to accelerate adoption to meet the recommendation and mitigate the identified risk. In view of this the 2nd revised date of March 2026 has been changed to September 2026.

15.3 **Audit action 040-24/25 from the 2024/25 internal audit on Exposure to Fumes** relates to ensuring systems currently used are designed to routinely capture the information required. Where possible any relevant date source was to be automated to transfer into the data vault. Completion of this audit action is dependent upon the Digital Directorate work plan and team capacity. It has been advised that automation of data transfer into the data vault will occur from May 2026. In view of these dependencies, a further (and 3rd) revised date of May 2026 has been applied.

15.4 **Audit action 053-24/25 from the 2023/24 internal audit on Vehicle Accident Management** relates to vehicle accident investigation guidance. The audit found that the Trust did not have any guidance of checklists in place to support line managers when undertaking investigations into vehicle accidents. The Trust committed to establishing a Task and Finish Group with key stakeholders to review current processes, develop and support the implementation of the guidance and a checklist for line managers. In Quarter 3 it was reported that the draft checklist has been presented to the Senior Operations Team resulting in some changes being incorporated. Following this the checklist will be tested in a local area prior to pan Wales rollout. A 2nd revised date of July 2026 has therefore been applied to afford sufficient time for testing, feedback and Trust-wide implementation of the checklist and guidance.

15.5 **Audit action 054-24/25 from the 2024/25 internal audit on Vehicle Accident Management** relates to driver training post-investigation. The audit found that where there is a need for drivers to undertake additional training post conclusion of an investigation, this is not formally documented by line managers, or maintained within a central listing by the Training Department to demonstrate completion. Such records would enable analysis of themes and trends, and repeat offenders to be identified. The Trust committed to establishing a Task and Finish Group with key

stakeholders to review current processes and documentation, agree where the central listing of documentation would be held and how this would be managed and monitored. A Task and Finish Group has reviewed the current processes in place and concluded that these are sufficient to meet the needs of reporting of investigations. Whilst the Task and Finish Group proposed that this action be closed, no evidence was supplied to support closure. A 2nd revised date of April 2026 has therefore been applied to afford sufficient time to collate and submit the required evidence.

Internal Audit: ARAC-specific Actions (Nil)

16. There were no open internal audit actions which fell under the purview of this committee during Quarter 3.

External Audit: Full Tracker Review (Annex 2 in reading room)

17. For Quarter 3, there were a total of 35 open external audit/review actions relating to the following:

Audit Year	Audit Title	No. of Recommendations
2023/24	Audit Wales: Quality Governance Follow Up Review	5
2024/25	Welsh Risk Pool: Concerns Assessment 2024	28
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*

18. Of the 35 open external audit actions, 12 (34%) were due for closure in quarter.

19. Following verification of evidence, eight (67%) actions were confirmed as completed and closed in quarter, this comprised of seven actions due in quarter (58%), and one action completed earlier than planned.

20. The Quarter 3 closure rate of external audit actions (67%) is a significant improvement on that reported in Quarter 2 (29%) and Quarter 1 (45%).

2023/24 - Quality Governance Review Follow-Up Audit (October 2024)

21. The five 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 10 February 2026.

22. Four of the seven open actions relating to this audit were confirmed as closed in quarter: two by their original deadlines, and the remaining two by their 1st revised date.

2024/25 - Welsh Risk Pool (WRP): Concerns Assessment 2024

23. At the beginning of Quarter 3, there were a total of 28 recommendations from the Welsh Risk Pool (WRP) Concerns Assessment 2024, eight of which were due to completed in quarter.

24. A total of five actions were confirmed as completed: 1 action by its original deadline, and the remaining four by their 1st revised date.

25. For the remaining four actions due in quarter which remain outstanding, 1st revised dates were applied: three of March 2026, and one of September 2026.

26. There are also four actions associated with this assessment for which completion dates have not yet been assigned.

27. The remaining 26 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 Q3	No. Actions Scheduled for Completion by Year and Quarter			Dates TBC (Depending on Digital)
		25/26 Q4	26/27 Q1	26/27 Q2	
No. Open WRP Actions	5	18	0	1	4

External Audit: – ARAC Actions

28. During Quarter 3, there were no open external audit actions in the purview of this committee.

Management and Development of the Tracker

29. Following implementation at the beginning of December 2025, Audit Tracker 3.0 was utilised by directorate points of contact to report Q3 updates and evidence supplied. Aside from a couple of refinements, no issues were identified or reported.

30. Initially access to the new tracker was restricted to Directors and directorate points of contact (Business Managers). This enabled tight controls to be maintained during the infancy / testing stage. However, as we now have confidence in the functionality of Audit Tracker 3.0, to enable visibility, view access has now been granted for all Responsible Officers to whom audit actions have been assigned.

31. The Responsible Officers having access to the tracker will also enable automated notifications to be sent via email to both them and the directorate point of contact, three months in advance of an audit action deadline – providing ample time for updates to be discussed and agreed within management teams, and the supply of relevant evidence.

32. Power BI support is in place supporting the development of this reporting, and it is planned for the Q4 audit reports to be in the form of a Power BI generated dashboard accompanied by an Executive Summary drawing out any matters of note.

RECOMMENDATION(S)

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

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

Agenda Item No.	12

REPORT TITLE

Trust Policy Report

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	02 March 2026
Public or Private	Public
If private - rationale	Choose item from below

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Lisa Trounce, Head of Compliance and Assurance

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

Purpose of the report

1. The purpose of this report is to provide the Committee with a six-monthly update on delivery of the 2025/26 Policy Work Programme and the Trust's position in relation to policy review date compliance. It outlines progress made, areas of risk or delay, and the trajectory towards year-end compliance.

Outstanding High Priority Policy Reviews Off Track – Update

2. In September 2025, the Committee was advised of a number of high-priority policies that were not progressing in line with the agreed timetable. Recovery plans have since been agreed and are being actively managed. The current position is summarised below:

High Priority Policies Off-Track – Update (February 2026)

Policy Title	2025/26 Priority	Status	Plan
Safer Handling Policy	**1**	Reviewed & Updated	Scheduled for Mar26 Policy Group meeting
Alternatives to Conveyance Policy	**1**	Post-consultation	Scheduled for Mar26 Policy Group meeting
Resourcing Policy *(interdependencies identified affecting timeframe of review)*	**1**	Under Review	Scheduled for Sep26 Policy Group meeting
Management of Safeguarding Allegations Policy	**2**	Under Review	Scheduled for Mar26 Policy Group meeting
High Risk Record Policy *(dependent upon Digital Work Plan prioritisation)*	**2**	Under Review	**Deferred to 2026/27**
MPDS QA Policy	**2**	Proposed Decommission	Scheduled for Mar26 Policy Group Meeting
Business Continuity Management Policy	**3**	Trust-wide Consultation	Scheduled for Mar26 Policy Group meeting

Progress Against the 2025/26 Policy Work Programme

3. An overview of the 62 policies which originally featured on the 2025/26 Policy Work Programme (as of 02/01/2026) is provided in the table below:

Stage of Development / Review / Approval Process	No. Policies	% (of 62)	% (of 62)
Approved	9	14.5%	**29%**
Recommended for Endorsement by ELT	1	1.6%	
Recommended for Approval by Committees	4	6.5%	
Post Consultation Review	1	1.6%	
Currently out for Trust-wide Consultation	0	0%	
Due for Trust-wide Consultation (with directorates for amendment)	3	4.8%	
Deferred with Planned Submission Dates Advised	25	40.0%	**40%**
Deferred until 2026/27 or ON HOLD	16	25.8%	**26%**
Policies Reclassified / Decommissioned / Superceded	3	4.8%	**5%**

Current Compliance and Compliance Trajectory

4. As of 02 January 2026, there were 80 existing Trust-owned policies, of which:

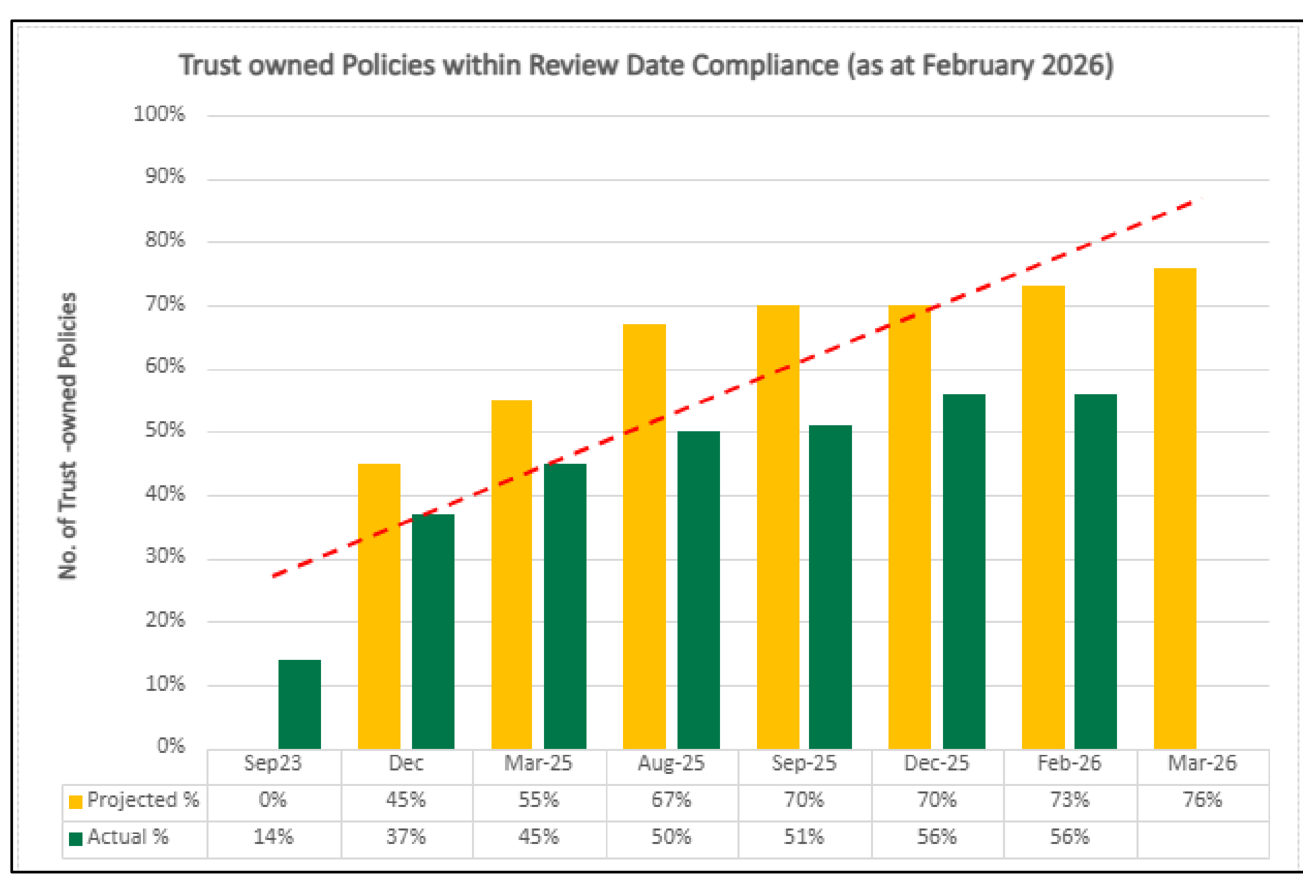
- 40 had already been approved
- 4 were awaiting committee approval, and
- 1 was to be submitted to ELT for endorsement.

This equates to 45 out of 80 policies **(56%) being within review date compliance** – an improvement of 6% since September 2025.

5. As anticipated, progress during the winter period was impacted by seasonal operational pressures (including REAP 4 escalation), annual leave and sickness absence.

6. Since the end of Quarter 2, the number of policies formally deferred to 2026/27 has slightly increased from sixteen to nineteen. Consequently, the maximum achievable compliance for 2025/26 has revised to 76.25%.

7. Based on current scheduling, fifteen policies are due for presentation to Policy Group in March 2026. If all proceed as planned and are subsequently approved, compliance could rise to approximately 75% (60 of 80 policies). However, a prudent and more realistic forecast for year-end compliance is 60–65%



	Sep23	Dec	Mar-25	Aug-25	Sep-25	Dec-25	Feb-26	Mar-26
Projected %	0%	45%	55%	67%	70%	70%	73%	76%
Actual %	14%	37%	45%	50%	51%	56%	56%	

Policies Deferred to 2026/27

8. Nineteen of the original 62 policies have been deferred to 2026/27 (sixteen existing policies and three new policies) – these are listed below. These deferrals have been approved by the Executive Leadership Team, taking account of:

- Directorate capacity constraints;
- Relative risk and priority of the policies concerned;
- Interdependencies with major programmes (e.g. Digital Work Plan, Clinical Model Transformation Programme, e-Timesheets Programme).

Policy Title	Directorate
Existing Policies Deferred to 2026/27	
Access Control Policy	Digital
Adverse Incident/Hazard Reporting Policy *****	Quality & Nursing
Assessment, Failure Referral and Appeals Policy	People & Culture
Confidentiality and Code of Conduct Policy	Digital
ePCR Policy *(previously Patient Clinical Records Policy)*	Digital
High Risk Records Policy	Operations
Information Classification Policy	Digital
Information Governance Policy	Digital
Information Sharing Policy	Digital
Management of Compensation Claims Policy *****	Quality & Nursing
NMC Revalidation and Registration Policy	Quality & Nursing
Policy for the Development, Review and Approval of Policies	Corporate Governance
Putting Things Right Policy *****	Quality & Nursing
Quality Assurance Framework for Clinical Desk Policy	Operations
Trust Mobile Phone Policy	Digital
New Policies Deferred to 2026/27	
Bring Your Own Device (BYOD) Policy	Digital
Research and Innovation Sponsorship Policy	Clinical
Stress Management Policy	People & Culture
Transgender Policy	People & Culture

**Three Quality and Nursing policies have been deferred pending publication of the new Putting Things Right Regulations ('Listening to Others') expected in Spring 2026. Subject to publication, these policies will be consolidated into a single overarching policy supported by a suite of standard operating procedures.*

Breakdown of Policies on Policy Tracker (February 2026)

9. At the beginning of 2025/26 (April 2025) there were a total of 124 live policies listed on the Trust's Policy Tracker – this total has now risen to 137 policies. The table below provides a breakdown of key movements:

Policy Classification	No. Policies	
	Apr 2025	Feb 2026
Trust owned policies within review date compliance	30	40
Trust owned policies on approval route	1	5
Trust owned policies c/f to 2025/26 Policy Work Programme	62	32 o/s
Trust owned policies c/f to 2026/27 Policy Work Programme	--	19
Externally owned policies (NHS Wales Employers Unit)	31	33
Total No. of Policies (Overall)	**124**	**129****

**Approved for reclassification to Standard Operating Procedures, Decommissioned, Superseded or Proposed New Policy now deemed as 'No Longer Required'.*

***Figure includes 1 new NHS Wales policies, plus 4 new Trust policies scheduled to be developed during 2025/26*

Reporting and Monitoring

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

Overall Assurance

11. The Trust has achieved measurable improvement in review date compliance since September 2025, strengthened oversight of high-priority policies, and established clearer governance controls around sign off processes. While year-end compliance will be below the original ambition due to approved deferrals and operational pressures, delivery remains on an improving trajectory with credible plans in place to sustain progress into 2026/27.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Audit, Risk and Assurance Committee is requested to:

1. **Approve** the updated Standards of Business Conduct Policy for onward travel to Trust Board
2. **Note** the progress against the 2025/26 Policy Work Programme (as at 18/02/2026)
3. **Receive** assurance regarding the planned approach regarding those policies which remain outstanding, to bring them within review date compliance.

ADDITIONAL PAPER(S)

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

The Audit, Risk and Assurance Committee is requested to receive the following:

Annex 1 Standards of Business Conduct Policy **[For Committee Approval]**

Annex 2 2025/26 Policy Work Programme (as at 18/02/2026)

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

Corporate Governance Directorate Risk

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

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

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

Risk Rating	Risk Score	Likelihood	Consequence
Current	**16**	4	4
Target	**8**	2	4

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
18 February 2026	Standards of Business Conduct Policy endorsed by Executive Leadership Team (ELT)
02 March 2026	Audit, Risk and Assurance Committee
26 March 2026 [planned]	Trust Board

Standards of Business Conduct Policy

Policy Number:	035	**Version No:**	3.6	**Supersedes:**	3.0 (Published 23/07/2023)
Date of Approval:	Tbc	**Review Date:**	3 years following approval	**Impact Assessments Completed:**	Yes
Classification of Document:	Corporate	**Type of Document:**	Policy	**Approved by:**	ARAC and Trust Board
Brief Summary of Document:	The Standards of Business Conduct policy describes the standards and public service values which underpin the work of the Welsh Ambulance Services University NHS Trust. In particular it sets out the specific arrangements for the appropriate declarations of interest, and the acceptance/refusal of offers of gifts, hospitality, and sponsorship.				
Scope:	This policy applies to WAST Non-Executive Directors and employees. For the purpose of this policy the term 'employees' encompasses individuals who are not direct employees of WAST and includes consultants, agency workers, specialist contractors, those who have an honorary contract with WAST, secondees who carry out work for WAST but are not directly employed by it, NHS Wales trainees on placement with WAST, jointly appointed staff and volunteers.				
To be read in conjunction with:	Nolan Principles Code of Conduct for NHS Managers UK Corporate Governance Code Standards for members of NHS boards and CCG governing bodies in England Working Time Policy Families Working Together Policy Working Time Regulations Policy				
Owning Committee	Audit, Risk and Assurance Committee				
Policy Lead: **Trade Union Lead:**	Lisa Trounce Damon Turner	**Job Title:**	Head of Compliance and Assurance Trade Union Partner		
Executive Director:	Trish Mills	**Job Title:**	Director of Corporate Governance / Board Secretary		

Version Control Sheet

Version	Date	Author	Summary of Changes
2.0	31/10/2017	Carl Window	Updated counter fraud legislation references
2.0	19/11/2017	Julie Boalch	Transposed to new template
2.0	13/02/2018	Keith Cox	Updated narrative
2.1	08/03/2018	Julie Boalch	Formatting
2.2	17/04/2018	Keith Cox	Comments post consultation
3.0	Mar 23	Trish Mills	This is a wholesale review of the current policy therefore this version does not have tracked changes. Changes include: • Includes 'decision makers' category. • Centrally held and published 'decision makers' interests. • Breaches and publication section added. • Included patents and IP. • Defined who is in scope. • Publication and reporting schedule. • Included sponsored posts. • Range of conduct inclusions such as political activity, social media, confidentiality, gambling, lending, borrowing, trading on WAST premises, insolvency/CCJs, arrest or conviction. • Clarity on interest categories and examples. • Options where gifts have been received and cannot be refused or donor found. • More particularity around hospitality including from contractors or suppliers. • Included family member connections in policy (previously was in form).

Version	Date	Author	Summary of Changes
			• Clear indication that all staff must provide declaration, even if nil declaration. • Detail on how to manage conflicts. • Crossover to standing orders and terms and conditions clearer. • Clarity on legacies. • Provides for gifts to be channelled to charity.
3.1	05/02/2025	Lisa Trounce	Contents of approved policy 3.0 (dated 23/07/2023) transferred to new WAST policy template in readiness for review.
3.2	16/07/2025	Lisa Trounce	Policy updated to: • Reflect the Trust's university status • Reflect appointment of Head of Compliance and Assurance and transfer of some Director of Corporate Governance/Board Secretary responsibilities • Incorporate suggested changes regarding donations to the WAST Charity • All references to the 'Audit Committee' amended to read 'Audit, Risk and Assurance Committee' • Clarification on some elements also sought from key stakeholders.
3.3	10/11/2025	Lisa Trounce	Amendments following clarification: • 10.4 - Removed as comments referenced DHSC not NHS in Wales. It can be dealt with in the Intellectual Property Policy on an All Wales basis. • 10.5 - Removed as part of usual rules re: secondary employment/declarations of interest. The NHS All Wales Intellectual Property Policy will address nuances.

Version	Date	Author	Summary of Changes
3.4	25/11/2025	Lisa Trounce	Updated policy prepared for Policy Group
3.5	03/12/2025	Lisa Trounce	Policy prepared for ELT endorsement
3.6	19/01/2025	Lisa Trounce	Policy prepared for presentation to ARAC and Trust Board for approval

Keywords	Declaration of interest, Gifts, Hospitality, Sponsorship, Conflict of interest

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	19/08/2025	Kelly Holding
EqIA / Welsh Language	17/07/2025	Kathryn Cobley / Melfyn Hughes
Environment	15/08/2025	Chris Davies
Quality	21/08/2025	Kate Blackmore

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	25 April 2023 20 June 2023	Initial review Final review after consultation
Executive Management Team	14 June 2023	Reviewed
Audit Committee	25 July 2023	Endorsed
Trust Board	27 July 2023	Approved
Policy Group	28/11/2025	Approval Recommended
Executive Leadership Team	14/01/2026	Endorsed
Audit, Risk & Assurance Committee	02/03/2026	For Endorsement
Trust Board	26/03/2026	For Approval

Disclaimer
If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Amb_policies@wales.nhs.uk

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1. INTRODUCTION AND AIM

1.1 The Standards of Business Conduct policy describes the standards and public service values which underpin the work of the Welsh Ambulance Services University NHS Trust (WAST / 'the Trust').

1.2 It is a long and well-established principle that public-sector organisations must be impartial and honest in their business and that their staff must act with integrity. As a publicly funded organisation, we have a duty to set and maintain the highest standards of conduct and integrity. We expect the highest standards of corporate behaviour and responsibility from Board members and all employees in accordance with our WAST behaviours.

1.3 The "Seven Principles of Public Life", or the "Nolan Principles" form the basis of the Standards of Behaviour requirements for WAST staff and Board Members. These are:

Selflessness – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends.

Integrity – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit.

Accountability – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position.

Openness – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.

Honesty – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership – Individuals should promote and support these principles by leadership and example.

2. POLICY STATEMENT

2.1 The Trust is committed to ensuring that its staff practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all staff are informed and supported in delivering that aim.

2.2 This Policy re-states and builds on the provisions of the Trust's Standing Orders. It reemphasises the commitment of the Trust to ensure that it operates to the highest standards, sets out key roles and responsibilities and the arrangements for ensuring that declarations can be made.

3. SCOPE

3.1 This policy applies to WAST Non-Executive Directors, employees and workers. For the purpose of this policy this encompasses individuals who are not direct employees of WAST and includes consultants, bank workers, agency workers, specialist contractors, those who have an honorary contract with WAST, secondees who carry out work for WAST but are not directly employed by the Trust, NHS Wales trainees on placement with WAST, jointly appointed staff and volunteers. This policy is relevant to all those persons and for ease of reference they are called 'staff' or 'staff member' in this policy.

Decision Making Officers

3.2 Some staff are more likely than others to have a decision-making role or influence on the use of public money because of the requirements of their role. In the context of this policy, the officers listed below are referred to as 'decision making officers', however additions may be made to this list from time to time:

(a) Board members (including Non-Executive Directors and Executive Directors);
(b) Executive Leadership Team (ELT);
(c) Assistant Directors Leadership Team (ADLT);
(d) Board and Committee attendees (per Committee terms of reference); and
(e) Staff on Band 8 and above not in the above.

3.3 Declarations made by decision making officers are published on the Trust's website in accordance with paragraph 9.21.

4. AIM

4.1 The aim of this policy is to ensure that arrangements are in place to support staff to act in a manner that upholds WAST's standards of behaviour as well as setting out specific arrangements for the appropriate declarations of interest and dealings with gifts, hospitality, and sponsorship.

5. OBJECTIVES

5.1 As well as promoting the standards of business conduct expected of public bodies, this policy aims to protect our organisation and staff from any suggestion of corruption, partiality, or dishonesty. It does this by providing a clear framework through which WAST can give guidance and assurance that staff conduct themselves with honesty, integrity, and probity, aligning to the Culture Health and Care Quality Standard 2023. The policy should be read in conjunction with that Standard and all relevant organisational policies, terms and conditions of employment/engagement, and related documents which are set out in the cover sheet.

6. FAILURE TO COMPLY WITH THE POLICY

6.1 Failure to comply with the requirements set out in this policy and any accompanying procedures may result in action being taken in accordance with the Trust's Disciplinary Policy and Procedure.

6.2 Where the failure to comply relates to an individual that is not a direct employee of the Trust, action may be taken in accordance with the relevant engagement procedures (e.g. termination of a secondment agreement).

6.3 Any financial or other irregularities or impropriety which involve evidence or suspicion of fraud, bribery, or corruption by any staff, will be reported to NHS Counter Fraud Authority or the Trust's Local Counter Fraud Specialists in accordance with its Standing Financial Instructions and the Counter Fraud and Corruption Policy, with a view to an appropriate investigation being conducted and potential prosecution being sought if deemed appropriate.

7. RAISING CONCERNS AND REPORTING BREACHES

7.1 This policy may be breached innocently, accidentally, or because of deliberate actions. Staff should speak up about any genuine concerns they have in relation to compliance with this policy. These can be raised directly with their own line manager, another senior manager or with the Head of Compliance and Assurance. Alternatively, staff can use the Trust's confidential third party platform for raising concerns known as Work In Confidence, further details of which can be found here.

7.2 All reported concerns will be treated with the appropriate confidentiality and investigated in line with WAST policies and procedures.

7.3 The Director of Corporate Governance/ Board Secretary will take a report on breaches and responses to the Audit, Risk and Assurance Committee and the Board on an annual basis.

8. WHAT ARE CONFLICTS OF INTEREST?

8.1 A conflict of interest is a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of carrying out their role is, or could be, impaired or influenced by another interest they hold.

8.2 A conflict of interest may be:

(a) Actual: there is a relevant and material conflict *now* between one or more interests of the member of staff; or

(b) Potential: there is the possibility of a material conflict *in the future* between one or more interests of a staff member.

8.3 Staff are expected to act at all times with the utmost integrity and objectivity and in the best interests of the organisation in performing their duties, and to avoid situations where there may be a potential conflict of interest. Staff must not use their position for personal advantage or seek to gain preferential treatment.

8.4 Staff are required to declare any actual or potential interests which may be perceived as conflicting with that overriding requirement.

9. DECLARATIONS OF INTERESTS

9.1 Staff are required to declare interests to ensure that, should they be involved in discussions or decisions that bring that interest into conflict with their role at the Trust, that can be managed appropriately. It also promotes transparency and the highest standards of business conduct. The fact that a staff member has declared an interest, whether that is ownership of a consultancy, a directorship, or a position of authority in a charity, does not assume it will in fact cause a conflict to arise at any stage.

9.2 Where a staff member does not hold any interests as set out in this policy, they must in any event return a 'nil declaration'. The form for declaring interests is at Annex 1 and enables staff to make this declaration simply and quickly.

9.3 Conflicts can occur because of interests held by the staff member, as well as interests held by a close family member, business partner, close friend, or associate. If staff are aware of material interests (or could reasonably be expected to know about these) then these should be declared. In this context, close family members are defined as:

(a) spouse or civil partner;

(b) any other person with whom the individual cohabits;

(c) children or stepchildren;

(d) spouse/partners' children or stepchildren;

(e) parents;

(f) grandparents; and

(g) siblings.

9.4 Staff may hold interests for which they cannot see any potential conflict. However, caution is always advisable because others may see it differently and may *perceive* an interest. It is important to exercise judgement and to declare such interests where there is otherwise a risk of suggestion of improper conduct. Where there is potential for interests to be relevant and material to the organisation, the interest must be declared. If in doubt, declare and/or seek advice from the Director of Corporate Governance / Board Secretary on the materiality of the interest you hold.

Categories of Interests Which Could Cause a Conflict

9.5 Interests can arise in a number of different contexts. A material interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision and may attract a benefit to the staff member. In this context, a benefit may be a financial gain or avoidance of a loss.

9.6 Interests can generally be considered in the following categories, although the examples are not exhaustive:

a) <u>Financial Interests</u>

This is where an individual may get direct financial benefit from the consequences of a decision they are involved in making. Some examples of financial interests you should therefore declare are as follows:

(i) Directorships, including Non-Executive Directorships held in private companies or public limited companies;

(ii) Ownership or part-ownership of private companies, businesses, or consultancies likely or possibly seeking to do business with the NHS;

(iii) Shareholdings and ownership interests in any publicly listed, private or not for profit company, business, partnership, or consultancy which are doing or might reasonably be expected to do business with the NHS. This includes shareholdings, debentures, or rights where the total nominal value is £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less;

(iv) Secondary employment (or in the case of a Non-Executive Director who is in employment, the details of that employment);

(v) Other commercial interests relating to a decision to be taken by the Trust;

(vi) Being in receipt of a grant or sponsored research;

(vii) Being in receipt of an honoraria.

b) Non-financial Professional Interests

This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career. Some examples of what you should therefore declare are set out below:

(i) An advocate for a particular group of patients;

(ii) A clinician with a special interest;

(iii) An active member of a particular specialist body;

(iv) An advisor for a WAST regulator (e.g., HIW).

c) Non-financial Personal Interests

This is where an individual may benefit personally in ways that are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions that they are involved in making in their professional career. Some examples of what you should therefore declare are set out below:

(i) A position of authority in another NHS organisation, commercial, charity trustee, voluntary, professional, statutory, or other body which could be seen to influence their role;

(ii) A position on an advisory group or other paid or unpaid decision-making forum that could influence how the NHS spends taxpayers' money;

(iii) Any connection with a private, public, voluntary, or other organisation contracting or likely to contract for NHS services;

(iv) Membership of a lobbying or pressure group with an interest in health and care;

(v) Membership of an organisation which might lead to conflict or might be perceived to do so.

(d) Indirect Interests

This is where an individual has a close association (see paragraph 9.3) with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision the staff is involved in making. It could also include a staff member's involvement in the recruitment or management of close family members and relatives and family members who work together.

(e) Loyalty Interests

As part of their role, staff may need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define. They are unlikely to be directed by any formal process or managed via any contractual means, however these 'loyalty' interests can influence decision making.

Declaring Interests

9.7 Staff must declare any relevant and material interests on the form at Annex 1. Declarations should be made as soon as is reasonably practicable, and within 28 days after the interest arises.

9.8 Staff are required to make their declarations interests as follows:

Officer Category	Frequency of Mode of Declaration
(a) Members of the Trust Board	• On appointment • Annually in March • In formal meetings where an interest is material • In relation to individual procurement exercises or contracts • When potential conflicts are identified Declarations will be held centrally by the Head of Compliance and Assurance (on behalf of the Director of Corporate Governance / Board Secretary) and placed on a register of declarations of interest.

Officer Category	Frequency of Mode of Declaration
(b) Decision-Making Officers	• On appointment • Annually in March • In formal meetings where an interest is material • In relation to individual procurement exercises or contracts • When potential conflicts are identified • When moving to a new role Declarations will be held centrally by the Head of Compliance and Assurance (on behalf of the Board Secretary) and placed on a register of declarations of interest. The Head of Compliance and Assurance will provide line managers of decision makers with copies of centrally held declarations.
(c) All Other Staff	• On appointment • Annually (even if a nil declaration is made) • When potential conflicts are identified • When moving to a new role Declarations are held by line managers and will be made available for inspection on request by the Head of Compliance and Assurance, Director of Corporate Governance / Board Secretary, Internal Audit and Audit Wales

9.9 If staff are in any doubt as to whether they have an interest or whether it is declarable, they should consult their line manager or the Head of Compliance and Assurance who can seek advice from the Director of Corporate Governance/Board Secretary.

Register of Declared Interests

9.10 The register of interests is maintained by the Director of Corporate Governance / Board Secretary who will formally record the declared interests of all staff. Interests will remain on the register for six months after they have expired at which point it will be removed from the register. Records will be kept in line with the Trust's Retention Policy. There may be occasions when a staff member declares an interest which the Board Secretary later agrees is not material. In such an instance the declaration will be recorded but not published.

Publication of Declarations

9.21 The register of interests of decision making officers will be published on the WAST website and updated where new interests arise. The register of interests of Board members and those attending Committees will be published on the WAST website and with the Board and Committee papers at each meeting.

9.22 In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available register. Where a staff member believes that substantial damage or distress may be caused to them or somebody else by the publication of information about them, they may make a request in writing to the Board Secretary. A confidential, un-redacted version of the register will be held securely by Head of Compliance and Assurance (on behalf of the Director of Corporate Governance / Board Secretary).

9.23 Staff should be aware that external organisations, e.g. Association of British Pharmaceutical Industries (ABPI), may also publish information relating to commercial sponsorship or other payments. The Trust will review such publications to ensure that appropriate internal declarations have been made in accordance with this policy and will take appropriate action where they have not.

Managing Conflicts of Interest - General

9.24 All declarations of interest must be reviewed by the appropriate line manager, and in the case of decision makers by the Head of Compliance and Assurance in conjunction with the Director of Corporate Governance/Board Secretary, with consideration given to any actions required to mitigate the conflict in the individual circumstances. However, it is not always possible to identify mitigations at the time of declaration.

These are often more appropriately made where the staff member's interests conflict with their role, for example where they are required to make or be involved in a decision. In such cases it may be necessary for the line manager to consider a range of possible actions which may include:

(a) Deciding that no action is warranted;

(b) Restricting the staff member's involvement in discussions and excluding them from decision making;

(c) Removing the staff member from the whole decision-making process;

(d) Removing the staff member's responsibility for an entire area of work; or

(e) Removing the staff member from their role altogether if the conflict is so significant that they are unable to operate effectively in the role.

9.25 An audit trail of the actions taken must be maintained by the line manager. The Board Secretary can provide advice on mitigations.

Managing Conflicts of Interest – In Meetings

9.26 All formal meetings, including of the Board and its Committees, must have a standing agenda item at the beginning of each meeting to determine whether there are any conflict of interest to declare in relation to the business to be transacted at the meeting. The Standing Orders and all Committee terms of reference will incorporate this requirement. Any new interests declared at the meeting should be included in the relevant register of interest by the Head of Compliance and Assurance as soon as practicable after the meeting.

9.27 In the event that the chair of the meeting has a conflict of interest, the vice chair is responsible for deciding the appropriate course of action to manage conflicts of interests. If the vice chair is also conflicted, then the remaining non-conflicted voting members of the meeting should unanimously agree how to manage the conflict(s).

9.28 When a member of the meeting (including the chair or vice chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or vice chair or remaining non-conflicted members where relevant as described above) must decide how to manage the conflict. The appropriate course of action will depend on the particular circumstances, but could include one or more of the following:

(a) Where the chair has a conflict of interest, deciding that the vice chair (or another non-conflicted member of the meeting if the vice chair is also conflicted) should chair all or part of the meeting;

(b) Requiring the individual who has a conflict of interest (including the chair or vice chair if necessary) not to attend the meeting;

(c) Ensuring that the individual does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict;

(d) Requiring the individual to leave the discussion while the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s);

(e) Allowing the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s);

(f) Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be an appropriate course of action where it is decided that the declared interest in either not material or not relevant to the matter(s) under discussion;

(g) Conflicts of interest arising at a Board meeting must be managed in accordance with the requirements of the Standing Orders.

9.29 In all cases a quorum must be present for the discussion and decision.

9.30 All decisions under a conflict of interest must be recorded by the meeting secretariat and clearly reported in the minutes of the meeting. The minutes will include:

(a) Who has the interest;
(b) The nature and extent of the conflict;
(c) An outline of the discussion;
(d) The actions taken to manage the conflict; and
(e) Evidence that the conflict was managed as intended.

9.31 To support chairs in their role, the secretariat will provide access to details of any conflicts which have already been made by members of the group.

10. PATENTS AND INTELLECTUAL PROPERTY

10.1 An All Wales Policy on Intellectual Property is in development and will be the primary policy statement for this area once approved. In the meantime, however, staff are to be guided by the following:

10.2 Staff should declare patents and other intellectual property rights they hold (either individually or by virtue of their association with a commercial or other organisation) relating to goods and services which are, or might reasonably be expected to be, procured, or used by the NHS.

10.3 Any patents, designs, trademarks or copyright resulting from the work (e.g. research) of a staff member carried out as part of their employment shall be the Intellectual Property of WAST.

10.4 Where holding of patents and other intellectual property rights give rise to a conflict of interest, then this must be declared.

11. PROCUREMENT

11.1 Conflicts of interest need to be managed appropriately through the whole procurement process. At the outset of any process, the relevant interests of individuals involved should be identified and clear arrangements put in place to manage any conflicts. This includes consideration as to which stages of the process a conflicted individual should not participate in, and in some circumstances, whether the individual should be involved in the process at all.

11.2 The Procurement Department (provided by the NHS Wales Shared Services Partnership) will seek to have staff working on a project with the Procurement Department complete a declaration of interest to ensure that there is no opportunity for conflicts to arise.

12. GIFTS

12.1 A gift is an item of personal value, given by a third party e.g., a patient or a supplier. This includes prizes in draws and raffles at sponsored events/conferences.

12.2 All staff must ensure that they are not placed in a position that risks, or appears to risk, compromising their role or the organisation's public and statutory duties or reputation. Staff should always refuse gifts or other benefits which might reasonably be seen to compromise their personal judgement or integrity.

12.3 The Bribery Act 2010 makes it a criminal offence to give or offer a bribe, or to request, offer to receive, or accept a bribe. The Act reformed the criminal law of bribery, making it easier to tackle this offence proactively in both the public and private sectors. It introduced a corporate offence which means that commercial organisations, including NHS bodies, will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

12.4 Staff should not ask for or accept gifts, gratuities, or honoraria from any individual or organisation that may be capable of being construed as being able to influence any decision or cast doubt on the integrity of such decisions. Staff are reminded that it may be considered to be a breach of the organisation Disciplinary Policy to solicit gifts. It may also be illegal, under the Bribery Act 2010, and staff that are found to have done so may face disciplinary action and prosecution.

12.5 Individuals offering gifts must be advised by the intended recipient that there is a requirement to declare and report such offers.

Gifts of Cash or Cash Equivalents

12.6 Under no circumstances should staff accept a personal gift of cash or cash equivalents (e.g., tokens, vouchers, gift cards, lottery tickets or betting slips) regardless of the value.

12.7 Such personal gifts are not acceptable and should be politely refused. However, the donor may be informed that should they wish to, they may make a donation to the Welsh Ambulance Service Charity ("the WAST Charity"):

Where cash is left by an unknown donor, and it is not possible to determine who the donor is, the cash should be donated to the WAST Charity.

(a) Where possible, potential donors should be directed to the Charity's online giving page (https://ambulance.nhs.wales/charity).

(b) If this is not feasible, the donor should be directed to the Charity Team (amb_charity@wales.nhs.uk) to make a donation via cheque or bank transfer.

(c) In the event that none of the above payment methods are viable, cash donations to the Charity may be accepted but must be stored securely and declared immediately to the Charity Team by emailing amb_charity@wales.nhs.uk. The Charity Team will then advise on local arrangements for how to securely deposit cash donations, in accordance with the Code of Fundraising Practice. Cash donations must be paid in as soon as practically possible, within a maximum timeframe of 10 working days.

Gifts (whether from patients, families, service users, foreign dignitaries, etc., but not suppliers or contractors – see further below)

12.9 Personal gifts of cash may not be accepted. However, as set out in paragraph 12.7 the donor may be directed to the WAST Charity.

12.10 The acceptance and declaration of gifts is dependent upon their value. A common sense approach should be applied to the valuing of gifts, using the actual amount if known, or an estimate that a reasonable person would make as to its value.

12.11 Gifts valued **up to £25**:

(a) Staff may accept gifts up to the value of £25 from patients/service users/relatives as a mark of their appreciation for the care that has been provided. This can include items such as chocolates, flowers, cards.

(b) There is no requirement to declare such gifts, however multiple gifts from the same source over a 12 month period should be declared where the cumulative value exceeds £25.

12.12 Gifts valued at **over £25**:

(a) Where a gift is offered that is likely to be over £25 in value it should be politely declined.

(b) In some cases, the gift may have been delivered and it may be difficult to return it or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, with the options for its use being agreed with the line manager and communicated to the donor:

- Share the gift with all staff;
- Donate the gift to the WAST Charity, where the Charity may raffle, auction or sell the gift to raise funds for the Charity; or
- Make a personal donation to the WAST Charity and keep the gift. In those circumstances the value of the gift will be agreed with the Director of Corporate Governance/Board Secretary.

(c) The gift must be declared via the form at Annex 2 and instructions set out on that form followed. A clear reason should be recorded as to why it was considered permissible to accept the gift, alongside the way it was used, actual or estimated value and include line manager approval.

12.13 If there is any doubt about the appropriateness of accepting a gift, staff should either politely decline or consult their line manager or the Director of Corporate Governance / Board Secretary.

Gifts from suppliers, contractors, customers etc.

12.14 Gifts from suppliers or contractors the NHS does business with, or is likely to do business with, or customers, should be declined, whatever the value. An exception to this is low cost branded promotional aids (such as calendars and pens) which may be accepted where they are valued at under £6 in total.

12.15 Gifts to a team or directorate of low value such as confectionary (up to £25) intended to be shared by the team or directorate may also be accepted. Gifts accepted from suppliers in accordance with this provision must be declared via the form at Annex 2 and instructions set out on that form followed. A clear reason should be recorded as to why it was considered permissible to accept the gift, alongside the actual or estimated value and include line manager approval.

12.16 Gifts from suppliers, contractors or customers that have been declined in line with this policy should be declared via the form at Annex 2 and instructions set out on that form followed. This will allow WAST to monitor when such organisations are inappropriately offering gifts or potential inducements.

Legacy in a Will

12.17 On occasions staff are left bequests in a service user's will which they become aware of before the service user is deceased or because they have been informed by the deceased service user's legal representative. In such circumstances the member of staff must immediately inform their manager. It should be borne in mind that staff cannot benefit from a bequest by virtue of their position as a Trust staff, undertaking their duties. If a member of staff receives a bequest they should contact the Director of Corporate Governance / Board Secretary.

Gifts from Dignitaries/Overseas Organisations

12.18 There may be occasions when visits are made by dignitaries or overseas organisations who consider it cultural custom and practice to exchange gifts. In such cases staff should seek guidance from the Board Secretary and declare these gifts. A decision will then be jointly made as to the most appropriate way to manage the gift. This will depend on the nature of the gift culture and may include decisions to keep and display in public, donate to an internal user group, auction for charity, etc.

Publication

12.19 The register of gifts, hospitality and sponsorship will be published on the WAST website following its presentation to the Audit, Risk and Assurance Committee annually.

13. HOSPITALITY

13.1 Hospitality is where there is an offer of food, non-alcoholic drink, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours.

13.2 Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.

13.3 Staff should exercise discretion in accepting offers of hospitality in case it would, or might appear to place them under any obligation to the individual or organisation making the offer; compromise their professional judgement and impartiality; or otherwise, be improper.

13.4 Hospitality should only be accepted on a one-off basis and should not take the form of regular events. It is very important that receiving hospitality does not influence, or is perceived to potentially influence, any decision making or behaviours.

13.5 Hospitality might be offered during working visits but may also be offered where:

(a) There is a genuine need to impart information, or represent WAST at stakeholder or community events which have an association with WAST;

(b) Staff are being invited to receive an award or prize in connection with the work of the organisation or their role within it;

(c) Staff are invited to a Society or Institute dinner or function which is to be funded by a commercial organisation and where there is a genuine benefit to the professional standing of the individual or WAST.

These types of hospitality must be authorised prior to their acceptance by the Director by completing the form at Annex 2 and instructions set out on that form followed.

13.6 Individual offering hospitality must be advised by the intended recipient that there is a requirement to declare and report such offers.

Hospitality from Suppliers or Contractors

13.7 Staff in contact with current or potential suppliers or contractors should be particularly mindful of accepting any hospitality that might later be misconstrued as impacting on strict independence and impartiality.

13.8 Offers can be accepted if modest and reasonable but must be declared and approved by the line manager.

Meals and Refreshments

13.9 Meals and refreshments (food and non-alcoholic drinks) which are equivalent to that offered in similar circumstances by NHS Wales can be accepted and need not be reported (unless it is offered by a supplier or contract – see paragraph 13.8).

13.10 Meals and refreshments offered of a value between £15 and £50 may be accepted and must be declared, indicating whether it has been accepted or declined, via the form at Annex 2 and instructions set out on that form followed.

13.11 Offers over a value of £50 should be refused unless (in exceptional circumstances) Director approval is given in advance of acceptance. A clear reason should be recorded on the declaration as to why it was permissible to accept hospitality of this value.

13.12 A common sense approach should be applied to the valuing of meals and refreshments, using an actual amount, if known, or an estimate.

Travel and Accommodation

13.13 Modest offers to pay some or all the travel and accommodation costs related to attendance at events may be accepted but must be declared. Offers which go beyond the type which would be funded by WAST must have Director approval in advance. A clear reason should be recorded on the declaration as to why it was permissible to accept travel and accommodation of this type.

13.14 Examples of travel and accommodation which would not normally be funded might include:

(a) offers of business or first-class travel and accommodation (including domestic travel);

(b) offers of foreign travel and accommodation;

(c) A holiday or weekend/overnight break;

(d) Offers of hotel accommodation when this is not associated with a sponsored source or conference;

(e) Use of a company flat or hotel suite.

13.15 Where a meeting is funded by the pharmaceutical industry, this must be disclosed in the papers relating to the meeting and in any published minutes or actions. The Department or Directorate organising or hosting the event must ensure that the funding has been approved in line with the requirements set out in the Commercial Sponsorship section of this policy.

Register of Gifts and Hospitality

13.16 The register of gifts and hospitality is maintained by the Head of Compliance and Assurance (on behalf of the Board Secretary) who will formally record the declarations of all staff. The register is reported to the Audit, Risk and Assurance Committee annually and available for public inspection.

14. SPONSORSHIP

Sponsored Posts

14.1 Staff who are considering entering into an agreement regarding the external sponsorship of a post within NHS Wales must seek formal approval. Staff will be required to demonstrate acceptance of a sponsored post is transparent and does not stifle competition.

14.2 Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of the arrangements continuing.

14.3 There should be written confirmation that the sponsorship arrangements will have no effect on any commissioning or other management decisions over the duration of the sponsorship and auditing arrangements should be established to ensure that this is the case. These written arrangements should set out the circumstances under which we may exit the sponsorship arrangements if conflicts of interest arise which cannot be mitigated.

14.4 Holders of sponsored posts must not promote or favour the sponsor's specific products or organisation and information about alternative suppliers must be provided.

14.5 Sponsors must not have any influence over the duties of the post or have any preferential access to services, materials or intellectual property related to or developed in connection with the sponsored post.

Sponsored Events

14.6 Sponsorship of events, including courses, conferences, and meetings, by external bodies should only be approved if it can be demonstrated that the event will result in

clear benefits for WAST. Sponsored events require the approval of the relevant Director in advance.

14.7 Sponsorship should not in any way compromise decisions or be dependent on the purchase or supply of goods or services.

14.8 Sponsors should not have any influence over the content of an event, meeting, seminar, publication, or training event.

14.9 WAST will not endorse individual companies or their products or services because of the sponsorship.

14.10 During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection (or other) legislation. As a general rule, information which is not in the public domain should not be supplied and no information should be supplied to a company for its commercial gain.

14.11 At WAST's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.

14.12 The involvement of a sponsor in an event should always be clearly identified in the interests of transparency.

14.13 All pharmaceutical companies entering into sponsorship agreements must comply with the Code of Practice for the Pharmaceutical Industry.

Sponsored Research

14.14 Funding sources for research purposes must be transparent. Any proposed research must go through the relevant approvals process.

14.15 There must be a written protocol and written contract and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services. Where the contract includes provision of people this, and accompanying arrangements, must be clearly articulated.

14.16 The study must not constitute an inducement to commission any service.

Declaring Sponsorship

14.17 Should there be any doubt about the appropriateness of accepting sponsorship, staff should seek advice from their line manager, Head of Compliance and Assurance or Board Secretary.

14.18 Declarations should include the value of the sponsorship. A common-sense approach should be applied to valuing the sponsorship if there is not a contractual value specified, for example a room and refreshments being provided for an event.

14.19 Sponsorship secured through, contracted by, paid directly to, or managed through a third party, such as exhibitors at our events sold through a third party or a sponsor paying for catering directly to an event venue should be declared.

14.20 Declarations should be made via the form at Annex 2 within 28 day of when the sponsorship was agreed rather than the date or the event. In exceptional circumstances where there are multiple sponsorship arrangements, the sponsorship may be declared within 28 days of the event taking place provided that this is agreed in advance by the relevant Director.

14.21 Declarations made in accordance with the policy will be published on the WAST website. In exceptional circumstances the value of the sponsorship may be published in bands where there are multiple sponsors of an event. A complete register will be held by the Head of Compliance and Assurance (on behalf of the Board Secretary).

14.22 The register of sponsorship is maintained by the Head of Compliance and Assurance, (on behalf of the Board Secretary) who will formally record the declarations of all staff.

15. MISCELLANEOUS PAYMENTS AND HONORARIA

15.1 Staff may be invited to give presentations at conferences, provide responses to surveys or attend professional meetings where a one off payment or honoraria is offered. The activity should be reported using a Gifts, Hospitality, Sponsorship and Honoraria Form and it should be authorised by the appropriate Director.

Honoraria Received for work undertaken during working hours

15.2 When appropriate authorisation has been granted to permit a staff member to be involved in activity outside their normal contract during working hours, any honoraria paid must be received back to the Trust revenue budget to reimburse the Trust for the staff member's time.

15.3 To avoid personal tax implications, staff are urged to request the Honoraria is paid directly to the Trust. This is then seen as reimbursement to the Trust to cover the loss of the staff member's time, and not honoraria. This money will then be transferred into the Trust revenue budget. The staff member who has undertaken the work must not be the budget holder for the budget receiving the funds in lieu of the honorarium due to a conflict of interest.

15.4 If the staff member receives the honoraria directly and then reimburses the Trust, the staff member remains liable for the payment of both tax and National Insurance Contributions (NIC), regardless of the final destination of the honoraria.

Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave)

15.5 Staff are personally liable for the payment of both tax and NICs on any honoraria payments received. Following their first honoraria declaration staff will be asked to sign a declaration statement confirming that they understand their responsibilities and this will be held on file by the Head of Compliance and Assurance (on behalf of the Director of Corporate Governance/Board Secretary).

15.6 If the staff member wishes to suggest a donation may be made to the Trust's Charitable Funds in lieu of an honoraria, this must be received into the Charity's general fund and it is then for the Charity to determine how the donated funds should be used. The basic principle being that the staff member giving their own time should have no influence over how the donation is then used and therefore lessens the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

15.7 In cases of doubt, staff should seek advice from the Director of Corporate Governance/Board Secretary and should report any case where an offer of sponsorship or honoraria is pressed which might be open to objection. Instances where honoraria

has been offered and declined should still be declared on the Gifts, Hospitality, Honoraria and Sponsorship Declaration Form.

16. SECONDARY EMPLOYMENT (AND CLINICAL PRIVATE PRACTICE)

16.1 All staff (depending on the details of their contract as regards secondary employment and private practice) are required to seek approval from their line manager if they are engaged in or wish to engage in secondary employment in addition to their work with WAST. This approval should be sought even if the staff member is temporarily absent from work e.g., through sickness, maternity leave, or secondment.

16.2 Secondary employment or private practice must neither conflict with nor be detrimental to the WAST work of the staff member in question. Examples of secondary employment or private practice which may give rise to a conflict of interest includes, but is not limited to:

(a) employment with another NHS body;

(b) working two roles internally for WAST;

(c) employment with another organisation which might be in a position to supply goods/services to the NHS in Wales; and

(d) self-employment, including private practice, in a capacity which might conflict with the work of the NHS in Wales or which might be in a position to supply goods/services to NHS in Wales.

16.3 Where a risk of conflict of interest is identified, these should be managed in accordance with the guidance provided at paragraph 9.24. WAST reserves the right to refuse permission where it reasonably believes a conflict will arise or that approval would be detrimental to the work of the staff member in question.

16.4 In undertaking any secondary employment, staff should have regard to section 'Trading on Official NHS Premises' at paragraph 19.12.

16.5 WAST may have legitimate reasons within employment law for knowing about secondary employment of staff, even where this does not give rise to the risk of a conflict of interest. Nothing in this policy prevents such enquiries being made.

Declaring secondary employment and private practice

16.6 All staff must declare any relevant secondary employment or private practice on appointment, and when any new employment arises, in accordance with the guidance above. Declarations should be made by via the form at Annex 1 and instructions set out on that form followed.

16.7 The register of secondary employment and private practice is maintained by the Head of Compliance and Assurance (on behalf of the Director of Corporate Governance/Board Secretary) who will formally record the declarations of all staff for the public record.

16.8 Managers will hold declarations submitted by staff on local personal files as per the guidance published on Siren.

17. CHARITABLE COLLECTIONS

Charitable Collections Individual

17.1 Whilst WAST supports staff who wish to undertake charitable collections amongst immediate colleagues, no reference or implication should be drawn to suggest that WAST is supporting the charity. Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage, birthday or a new job.

Charitable Collections - Organisational

17.2 The Welsh Ambulance Service Charity is WAST's only official charity. If it is proposed to use the WAST brand as part of fundraising for any other charitable cause, this must be authorised and documented by the appropriate Director in advance and reported to the Director of Partnerships and Engagement.

18. POLITICAL ACTIVITY

18.1 Any political activity should not identify an individual as a staff member of WAST. Conferences or functions run by a party-political organisation should not be attended in an official capacity, except with prior written permission from the Director of Partnerships and Engagement.

19. PERSONAL CONDUCT

Corporate Responsibility

19.1 All staff have a responsibility to respect and promote the corporate or collective decision of WAST, even though this may conflict with their personal views. Staff may comment as they wish as individuals however, if they decide to do so, they should make it clear that they are expressing their personal view and not the view of WAST.

19.2 When speaking as a staff member of WAST, whether to the media, in a public forum or in a private or informal discussion, staff should ensure that they reflect the current policies or view of the organisation.

19.3 For any public forum or media interview, approval should be sought in advance. In the case of the Board, approval is from the Chairman and/or Chief Executive with advice from the Head of Communications. In the case of all other staff, the Head of Communications will provide the approval. Where this is not practicable, they should report their action to the Chairman (for Board members) and Head of Communications for all others as soon as possible.

19.4 All staff must ensure their comments are well considered, sensible, well informed, made in good faith, in the public interest and without malice and that they enhance the reputation and status of WAST.

19.5 Staff must follow the guidance for communication with the media; disciplinary action may be taken if this is not followed.

Use of Social Media

19.6 As at the date of revision of this policy an All Wales Social Media Policy is in development. When that policy is adopted by WAST it will take precedence should any element of this policy contradict that All Wales position.

19.7 Staff should be aware that social networking websites are public forums and should not assume that their entries will remain private. Staff communicating via social media must comply with the relevant organisational social media and associated policies. Staff must not conduct themselves in a way that brings WAST into disrepute, or disclose information that is confidential to WAST, its staff or patients. Only Trust authorised

applications (including social media and communication applications) may be used to process Trust information.

Confidentiality

19.7 Staff must, at all times, operate in accordance with the UK General Data Protection Regulation, the Data Protection Act 2018, and all internal Information Governance (IG) policies, procedures and guidance. They are required to maintain the confidentiality, integrity and security of all information, including but not limited to patient information, personal information relating to staff, and commercially sensitive data. This duty of confidence is absolute and continues indefinitely, even after staff (however employed) leave WAST. Any breach of this duty may result in disciplinary, regulatory or legal action.

19.8 For the avoidance of doubt, this does not prevent the disclosure or information where there is a lawful basis for doing so (e.g., consent). Staff should refer to the suite of WAST Information Governance and Corporate Information Technology policies for detailed information.

Gambling

19.9 No staff member may bet or gamble when on duty or on WAST premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among immediate colleagues within the same offices where no profits are made or the lottery is wholly for purposes that are not for private or commercial gain.

Lending and Borrowing

19.10 The lending or borrowing of money between staff should be avoided, whether informally or as a business, particularly where the amounts are significant.

19.11 It is a particularly serious breach of discipline for any staff member to use their position to place pressure on someone in a lower pay band, a business contact, or a member of the public to loan them money.

Trading on WAST Premises

19.12 Trading on official premises is prohibited, whether for personal gain or on behalf of others. This includes but is not limited to flyers advertising services/products in common areas, or catalogues in common areas.

19.13 Canvassing within the office by, or on behalf of, outside bodies or firms (including non-WAST interests of staff or their relatives) is also prohibited.

19.14 Trading does not include small tea or refreshment arrangements solely for staff.

Individual Voluntary Arrangements, County Court Judgment (CCJ), Bankruptcy / Insolvency

19.15 Any staff member who becomes bankrupt, insolvent, has active County or High Court Judgment, or has made an individual voluntary arrangement with an organisation must inform their line manager and the People and Culture Directorate as soon as possible. Staff who are bankrupt or insolvent cannot be employed, or otherwise engaged, in posts that involve duties which might permit the misappropriation of public funds or involve the approval of orders or handling of money.

Arrest or Conviction

19.16 A staff member who is arrested, subject to continuing criminal proceedings, or convicted of any criminal offence must inform their line manager and the People and Culture Directorate as soon as is practicably possible.

20. ANNUAL ELIGIBILITY REVIEWS

20.1 Board Members will, on appointment and annually, declare that they are eligible to hold the office of Board Member. These declarations extend to members of the Executive Leadership Team who are not voting members of the Board and to Trade Union Representatives on the Board.

20.2 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in the Membership Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister of Health and Social Services in writing of any such cases immediately.

20.3 The Director of Corporate Governance/Board Secretary will undertake annual due diligence checks at the same time as receiving the eligibility declarations. These will include disqualified director and trustee searches, and bankruptcy and insolvency searches. In addition, the Director of Corporate Governance/Board Secretary will ensure that all members have had a DBS and have had or are undergoing their annual appraisal.

20.4 Completion of annual eligibility reviews will be reported to the Remuneration Committee.

21. ROLES AND RESPONSIBILITIES

21.1 The **Chief Executive** is the Accountable Officer with overall responsibility for ensuring that the Trust operates efficiently, economically and with probity. The Chief Executive will ensure a policy framework is set and that arrangements are in place to support the delivery of that framework.

21.2 The **Chair** will:

(a) Ensure that Non-Executive Directors Board are aware of the requirements contained within this Policy;

(b) Lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality, or sponsorship;

(c) Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered to Non-Executive Directors prior to the event.

21.3 The **Executive Director of Finance and Corporate Resources** is responsible for ensuring appropriate monitoring arrangements are established to ensure that purchasing decisions are not being influenced by a sponsorship agreement.

21.4 The **Director of Corporate Governance/Board Secretary** will:

(a) Review the content of declarations of interest made by decision makers on receipt;

(b) Review the contents of declarations of gifts, hospitality and sponsorship made and the advice subsequently provided by Line Managers to ensure that the recommended action is compliant with Trust policy. The Board Secretary will liaise directly with the relevant Line Manager in instances where this is not considered to be the case;

(c) Advise staff on all aspects of this policy;

(d) Ensure arrangements are in place to prompt staff to complete a Declaration of Interest Form on initial employment with WAST and at periodic intervals thereafter;

(e) Ensure that a Register of Interests and a Register of Gifts, Hospitality and Sponsorship is established and maintained as a formal record of interests declared by staff;

(f) Report the content of those registers and the effectiveness of the arrangements in place to the Audit, Risk and Assurance Committee at agreed intervals, including any breaches of this policy.

21.5 The **Head of Compliance and Assurance** will:

(a) Ensure that the appropriate forms and paperwork for declaring an interest are available on the intranet;

(b) On behalf of the Director of Corporate Governance/Board Secretary ensure arrangements are in place to prompt staff to complete a Declaration of Interest Form on initial employment with WAST and at periodic intervals thereafter;

(c) On behalf of the Director of Corporate Governance/Board Secretary, ensure that a Register of Interests and a Register of Gifts, Hospitality and Sponsorship is established and maintained as a formal record of interests declared by staff;

(d) Published those registers on the WAST Website in accordance with the requirements of the organisation's Freedom of Information Publication Scheme;

(e) Report the content of those registers and the effectiveness of the arrangements in place to the Audit, Risk and Assurance Committee at agreed intervals, including any breaches of this policy.

21.6 **Directors** will:

(a) Lead by example and ensure that they personally declare any interests the subject of this policy;

(b) Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered within their Directorate prior to the event;

(c) Ensure that they review the contents of the Register of Declarations on an annual basis to assist with the verification of the information contained within it.

21.7 **Line Managers** will:

(a) Ensure that staff are aware of the requirements of this policy and the implications for their work, particularly at annual PADR discussions;

(b) Support individuals in their declaration applications, seeking advice from other managers or from the Head of Compliance and Assurance or Board Secretary if required;

(c) Ensure any declarations of interest are managed in accordance with this policy.

21.8 **All staff** will:

(a) Ensure they are aware of and are compliant with the requirements of this policy, consulting their line manager or appropriate senior manager if they require clarification;

(b) Declare to WAST any relevant interests, gifts, hospitality, and sponsorship;

(c) Obtain permission from their line manager/Director before accepting gifts, hospitality, or sponsorship;

(d) Verbally declare any relevant interest when a potential for conflict arises e.g., at Board and Committee meetings, during procurement process etc;

(e) Observe the Standing Orders, Standing Financial Instructions and procurement policies and procedures of the Trust.

21.9 An annual training package to raise awareness and understanding of this policy will be included in the WAST training for all staff. All decision making officers will be required to submit an annual attestation that all appropriate declarations required by the policy have been submitted.

22. IMPACT ASSESSMENTS

22.1 Equality Impact Assessment

An Equality Impact Assessment initial screening was undertaken on this policy and it was assessed not to be significant from the perspective of the application of the Equality Act 2010, and that no negative impact on the protected characteristics within the legislation were identified. A full Equality Impact Assessment was not required.

22.2 Welsh Language Assessment

The Welsh Language (Wales) Measure 2011 has given the Welsh language official status in Wales by introducing Welsh Language Standards for organisations. The duties deriving from the standards mean that the Trust and all of its employees should not treat the Welsh language less favourably than the English language together with promoting and facilitating the use of the Welsh language. The Equality Impact Assessment took account of Welsh Language, and it was found to be neutral/no impact.

22.3 Environmental Impact Assessment

This policy will put the relevant requirements in place (such as waste management plan, reduction of CO2 emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services University NHS Trust's ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and ISO14001 Environmental Governance System.

23. COUNTER FRAUD

The Welsh Ambulance Services University NHS Trust is committed to taking all necessary steps to counter fraud, bribery, and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively, staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or via the online reporting facility https://cfa.nhs.uk/reportfraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

24. RECORDS MANAGEMENT

The Welsh Ambulance Services University NHS Trust recognises the importance of sound records management arrangements for both clinical and corporate records. The Trust's records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

25. INFORMATION GOVERNANCE

Information Governance (IG) is an overarching term used to describe all aspects of information management.

The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

26. HEALTH AND SAFETY

The health, safety and well-being of staff, volunteers and contractors who work for the Trust is of paramount importance.

The Management of Health and Safety at Work Regulations 1999 require the Trust to make a suitable and sufficient assessment of the risks to the health and safety of its employees to which they are exposed whilst they are at work and the risks to the health and safety of anyone else affected by the activities of the Trust.

27. AUDIT AND MONITORING

Monitoring for compliance with this policy will be by way of:

(a) Register of Interests publicly available on the Trust website
(b) Register of Interests reported to the Audit, Risk and Assurance Committee annually
(c) Register of Gifts, Hospitality and Sponsorship reported to the Audit, Risk and Assurance Committee annually

28. REFERENCES

Not Applicable

29. APPENDICES

Appendix 1	Declarations of Interests Form
Appendix 2	Declarations of Gifts, Hospitality and Sponsorship Form

APPENDIX 1 - This form should be downloaded separately from the Trust's Intranet here.

DECLARATION OF INTERESTS FORM

Please review the Standards of Business Conduct Policy for details of interests which may be relevant and material and therefore subject to declaration. The policy can be found on the Trust's Intranet here.

All staff should make a declaration - even where it is a 'nil' declaration i.e., you do not have any interests to declare.

For 'decision making officers' as defined in the policy, this form is reviewed by the Head of Compliance and Assurance (on behalf of the Board Secretary) and provided to your line manager for their review. It is placed on the Register of Interests which is maintained by the Head of Compliance and Assurance (on behalf of the Board Secretary), provided to the Audit Committee annually, and published on the Trust's website.

Full Name	
Position	
Directorate	
Employee Number	
Line Manager's Name and Position	

Section A: Nil Declaration:

I do not hold any of the interests set out below, and have nothing to declare:	☐

If you have completed Section A go straight to sign off section C

Section B: Interests to Declare:

Refer to the policy for full details but note that you will not automatically be conflicted just because you hold some of the interests set out below. A conflict may arise where you interests do not align to decisions you are making, or where there is a perception that they do not align. In those circumstances a mitigation plan will be put in place.

Interest Declared that relate to you	Details of Interest including the full name of any organisations/companies/directorships	Date Interest Commenced
Financial Interest This is where you may get direct financial benefit from the consequences of a decision you are involved in making. This may include but is not limited to: • Directorships, including Non-Executive Directorships held in private companies or public limited companies; • Ownership or part-ownership of private companies, businesses, or consultancies likely or possibly seeking to do business with the NHS • Shareholdings and ownership interests in any publicly listed, private or not for profit company, business, partnership, or consultancy which are doing or might reasonably be expected to do business with the NHS Secondary employment (or in the case of a Non- Executive Director who is in employment, the details of that employment)		

Interest Declared that relate to you	Details of Interest including the full name of any organisations/companies/directorships	Date When Interest Commenced
• Other commercial interests relating to a decision to be taken by the Trust • Being in receipt of a grant or sponsored research • Being in receipt of an honoraria		
Non-Financial Professional Interest This is where you may obtain a non-financial professional benefit from the consequences of a decision you are involved in making, such as increasing your professional reputation or status or promoting your professional career. This may include but is not limited to where you are: • An advocate for a particular group of patients • A clinician with a special interest • An active member of a particular specialist body • An advisor for a WAST regulator (e.g., HIW)		
Non-financial personal interests This is where you may benefit personally because of decisions that you are involved in making. This may include but is not limited to where you are in:		

Interest Declared that relate to you	Details of Interest including the full name of any organisations/companies/directorships	Date When Interest Commenced
A position of authority in another NHS organisation, commercial, charity, voluntary, professional, statutory, or other body which could be seen to influence your role A position on an advisory group or other paid or unpaid decision-making forum that could influence how the NHS spends taxpayers' money Any connection with a private, public, voluntary, or other organisation contracting or likely to contract for NHS services Membership of a lobbying or pressure group with an interest in health and care Membership of an organisation which might lead to conflict, or might be perceived to do so		

Indirect interests This is where you have a close association with an individual (relative/friend/business associate) who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision the officers is involved in making. If you are aware of material interests, or could reasonably be expected to know about these, then they should be declared.	*Include here the details of the interest of the individual(s) with whom you have a close association and their relevant interests.*	
Interest Declared that relate to you	**Details of Interest including the full name of any organisations/companies/directorships**	**Date When Interest Commenced**
Loyalty interests As part of you role you may need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define. They are unlikely to be directed by any formal process or managed via any contractual means, however these 'loyalty' interests can influence decision making.		

Section C: Declaration

I declare that the information I have given on this form is correct and complete and that I will not create a conflict of interest between my NHS employment and an external body/organisation or my personal interests. I understand that if I knowingly provide false information or fail to disclose relevant information, this may result in disciplinary action and I may be liable to prosecution and/or civil proceedings. I f acknowledge that the information on this form may be disclosed to the Trust's Auditors for review, and understand the form may be reviewed for the purpose of fraud prevention and detection by NHS Counter Fraud Specialists. I agree to submit further notices in order to bring up to date information given in this notice and will declare any interest I acquire after the date of this notice. I agree to publication of my interests on the public record on the
Trust website.

Signature of person making this declaration	
Date of Signature	

As line manager of the person making this declaration I confirm that I have reviewed the declaration. I do not consider that the interests declared (if any) present an immediate conflict and will manage any conflicts that may arise from time to time in accordance with the Standards of Business Conduct Policy

Signature of line manager	
Date of Signature	

The Line Manager is required to retain these declarations for inspection on request by members of the Executive Team, Internal/ External Audit or the Counter Fraud Officer.

APPENDIX 2 - This form should be downloaded separately from the Trust's Intranet here

DECLARATION OF GIFTS, HOSPITALITY, AND SPONSORSHIP

Extracts of the gifts, hospitality, and sponsorship section of the Standards of Business Conduct Policy are set out below for context and ease of reference, however staff are requested to review the Policy before completing this form. The policy can be found on the Trust's Intranet here.

Complete the relevant section of this form for declaration of receipt or offer of a gift, hospitality (including travel and accommodation) or sponsorship.

This form must be authorised by your line manager or Director and reviewed and held centrally by the Board Secretary. Your declaration will be placed on the Register of Interests which is maintained by the Board Secretary, provided to the Audit Committee annually, and published on the Trust's website. The Board Secretary can be contacted for advice on the Policy and this form directly or via amb_corporategovernance@wales.nhs.uk.

Full Name	
Position	
Directorate	
Employee Number	
Signature	
Date	

A declaration must be made even where a gift or hospitality has been declined.

1. GIFTS

Staff must not be placed in a position that risks, or appears to risk, compromising their role or the organisation's public and statutory duties or reputation. Staff should always refuse gifts or other benefits which might reasonably be seen to compromise their personal judgement or integrity.

Staff may accept gifts up to the value of £25 from patients/service users/relatives as a mark of their appreciation for the care that has been provided. These may be items such as chocolates, flowers etc. **There is no requirement to declare these gifts unless** the gift is from a supplier, or multiple gifts from the same source over 12 months have a cumulative value over £25.

Cash or cash equivalents (tokens, gift cards, vouchers etc) **of any value must not be accepted**. Where cash has been left by a donor who cannot be traced it may be deposited to the WAST Charity.

Gifts over £25 should be declined, but where that is not possible the gift **must be declared on this form.** In some cases, the gift may have been delivered and it may be difficult to return it or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, with the options for its use being agreed with the line manager in line with section 12 of the Policy.

Gifts from suppliers or contracts should be declined whatever the value, other than low cost branded promotional items such as calendars and pens. Any gifts from suppliers, regardless of the

value **must be declared on this form**. Likewise, any offers of gifts *declined* from suppliers or contracts must be declared.

Where a gift is required to be declared in line with the Policy, the following information is required. Your line manager or the Board Secretary can provide advice.

Details of gift including date it was offered	
Estimated value of gift	
Name of donor if known	
Was the gift refused?	
Where gift could not be refused, why it was considered suitable to accept the gift	
How the gift was used	

2. HOSPITALITY

Hospitality is where there is an offer of food, non-alcoholic drink, accommodation, entertainment, travel or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours.

Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.

Staff should exercise discretion in accepting offers of hospitality in case it would or might appear to place them under any obligation to the individual or organisation making the offer; compromise their professional judgement and impartiality; or otherwise, be improper. This is particularly important when it is offered by current or potential suppliers or contractors.

Meals and refreshments which are equivalent to that offered in similar circumstances by NHS Wales can be accepted and need not be declared. This may arise for example as part of a conference.

Meals and refreshments offered of a value between £15 and £50 may be accepted and must be declared. This may be signed off by your line manager.

Offers over a value of £50 should be refused unless (in exceptional circumstances) **Director approval** is given in advance of acceptance. A clear reason should be recorded on the declaration as to why it was permissible to accept hospitality of this value.

Modest offers to pay some or all the **travel and accommodation** costs related to attendance at events may be accepted but must be declared.

Details of hospitality including date	
Estimated total value of hospitality (including a breakdown of costs). **NB: Where the value is over £50 provide reason why accepted.**	
Name of provider of hospitality	
Is the provider of the hospitality a current or potential supplier or contract	**Yes** ☐ **No** ☐ **Not known** ☐

3. SPONSORSHIP

Sponsorship of events, including courses, conferences, and meetings, by external bodies should only be approved if it can be demonstrated that the event will result in clear benefits for WAST. Sponsored events require the approval of the relevant Director in advance.

Sponsorship of a post and of research are dealt with in more detail in the Policy at section 14.

Details of sponsorship including date	
Estimated value of sponsorship	

4. LINE MANAGER/DIRECTOR DECLARATIONS

a. I have reviewed this declaration and consider the action taken by the individual are appropriate.

Full Name	
Position	
Signature	
Date	

or

b. I have reviewed this declaration and consider the action taken by the individual is not appropriate and I have advised the individual accordingly as set out below.

Reasons for considering offer not appropriate	
Full Name	
Position	
Signature	
Date	

Once completed and signed this form must be sent to the Head of Compliance and Assurance directly or via amb_corporategovernance@wales.nhs.uk.

NB: Please ensure that you have recorded the dates when declared interests commenced. Thank you

Policy Group Meeting Dates 2025/26:

Month	Date	Time	Deadline for Papers
May	30/05/2025	2:30 - 4:00pm	Fri 09/05/2025
June	30/06/2025	3:00 - 5:00pm	Fri 13/06/2025
July	28/07/2025	2:30 - 4:30pm	Fri 11/07/2025
August	28/08/2025	9:00 - 11:00am	Fri 08/08/2025
September	22/09/2025	2:30 - 4:30pm	Fri 05/09/2025
October	29/10/2025	9:30 - 11:30am	Fri 10/10/2025
November	26/11/2025	9:30 - 11:30am	Fri 07/11/2025
December	15/12/2025	2:30 - 4:30pm	Fri 28/11/2025
January	26/01/2026	2:00 - 4:00pm	Fri 09/01/2026
February	19/02/2026	10:30am - 12:30pm	Fri 06/02/2026
March	19/03/2026	10:30am - 12:30pm	Fri 06/03/2026

Policy Title	25/26 Priorities	25/26 Policy Work Programme (ADLT	Directorate	Policy Type	Last Issue Date	In Progress / Stage
Information Risk Policy	**Already on Approval Route**	**May-25**	DIGITAL	Corporate	20/05/2025	Approved
Estates, Environmental and Facilities Management Policy **[New]**	**1**	**May-25**	FINANCE & CORPORATE	Corporate	18/11/2025	Approved
CCTV Policy	**1**	**Sep-25**	DIGITAL	Corporate	25/04/2020	For Approval
Violence & Aggression Policy	**1**	**May-25**	QS&PE	Employment	04/02/2024	Further Work Required
Lone Worker Policy	**1**	**May-25**	QS&PE	Employment	13/11/2025	Approved
Safer Handling Policy	**1**	**May-25**	QS&PE	Employment	01/12/20	Further Work Required
Alternatives to Conveyance Policy	**1**	**Jun-25**	CLINICAL	Clinical	01/11/10	Post Consultation
Resourcing Policy	1	**Jun-25**	OPERATIONS	Employment	01/03/14	Under Review
Transfer Policy	1	**Jun-25**	OPERATIONS	Employment	10/03/20	Approved
Carers Policy [NEW]	2	**May-25**	PEOPLE & CULTURE	Employment	n/a	Approved
Artificial Intelligence Policy **[NEW 2025]**	2	**Nov-25**	DIGITAL	Corporate	New	New
Management of Safeguarding Allegations Policy	2	**Jul-25**	QS&PE	Corporate	27/02/18	Under Review
MPDS QA Policy	2	**Jul-25**	OPERATIONS	Clinical	10/01/19	Under Review
Fuel Card Policy	2	**May-25**	FINANCE & CORPORATE	Corporate	30/05/25	Approved
Vehicle Disposal Policy	3	**May-25**	FINANCE & CORPORATE	Corporate	30/05/25	Approved
Tyres and Wheels Policy	3	**Aug-25**	FINANCE & CORPORATE	Corporate	16/07/19	Under review
Vehicle Telematics Policy	3	**Aug-25**	FINANCE & CORPORATE	Corporate	10/05/18	Under Review

Freedom of Information Policy	3	Sep-25	CORPORATE GOVERNANCE	Corporate	New	Out for Consultation
Business Continuity Management Policy	3	Jul-25	OPERATIONS	Corporate	24/10/19	Under Review
Prevent Policy **[New]**	3	Aug-25	QS&PE	Corporate	04/11/25	Approved
Workplace Reintegration and Skills Refresher Policy **[New]**	4	Jun-25	QS&PE	Employment	New	Post Consultation
People Development Policy	6	Aug-25	PEOPLE & CULTURE	Employment	New	Approved
Working Time Regulations Policy	6	Sep-25	PEOPLE & CULTURE	Employment	01/07/04	Further Work Required
Maternity Policy	6	Aug-25	PEOPLE & CULTURE	Employment	10/05/18	Under Review
Paternity Policy	6	Aug-25	PEOPLE & CULTURE	Employment	10/05/18	Under Review
Shared Parental Leave Policy	6	Aug-25	PEOPLE & CULTURE	Employment	10/05/18	Under Review
Access to Personal Information Policy	6	Sep-25	DIGITAL	Corporate	25/04/19	Under Review
Managing Families and Relatives Working Together Policy	5	Nov-25	PEOPLE & CULTURE	Employment	10/03/20	For Consultation
Adverse Weather Conditions Policy	5	Jan-26	PEOPLE & CULTURE	Employment	05/07/18	For Consultation
Relocation Expenses Policy	5	Mar-26	PEOPLE & CULTURE	Employment	10/01/19	Proposed Policy Reclassification
Redeployment Policy	5	Jan-26	PEOPLE & CULTURE	Employment	25/02/20	Under Review
Study Leave Policy	5	Dec-25	PEOPLE & CULTURE	Employment	01/06/15	Proposed Policy Reclassification
Fire Safety Policy	5	Aug-25	FINANCE & CORPORATE	Corporate	17/03/22	Under Review
Command Policy	5	Feb-26	OPERATIONS	Corporate	25/04/23	Under Review
NMC Revalidation and Registration	5	Sep-25	QS&PE	Employment - All Wales	04/09/18	Under Review

Children in Special Circumstances Policy		Jul-25	QS&PE	Clinical	28/11/2017	Proposed Policy Decommission
Risk Management Policy	Routine Review	Jun-25	CORPORATE GOVERNANCE	Corporate	02/09/25	Approved
Home Working Policy	Routine Review	Aug-25	PEOPLE & CULTURE	Employment	28/08/25	Approved
Standards of Business Conduct Policy	Routine Review	Jul-25	CORPORATE GOVERNANCE	Corporate	27/07/23	For Approval
High Risk Record Policy	2	Jul-25	OPERATIONS	Corporate	16/07/20	Under Review
ePCR Policy *[previously Patient Clinical Record Policy]*	3	Jan-26	DIGITAL	Clinical	New	New
Charitable Funds Policy **[New]**	5	Aug-25	PARTNERSHIP & ENGAGEMENT	Corporate	New	New
Assessment, Failure Referral and Appeals Policy	5	Nov-25	PEOPLE & CULTURE	Employment	01/02/16	Under Review
Bursary Scheme Policy	5	Feb-26	PEOPLE & CULTURE	Employment	01/08/16	Proposed Policy Reclassification
Adverse Incident/Hazard Reporting Policy	5	Apr-25	QS&PE	Clinical	25/04/23	Under Review
Putting Things Right Policy	5	Apr-25	QS&PE	Corporate	25/04/23	Under Review
Management of Compensation Claims Policy	5	Aug-25	QS&PE	Corporate	26/02/19	Under Review
Bring Your Own Device (BYOD) Policy	5	Dec-25	DIGITAL	Corporate	New	New
Policy for the Development, Review and Approval of Policies	8	Mar-26	CORPORATE GOVERNANCE	Corporate	28/03/19	Under Review
Confidentiality and Code of Conduct	5	**2026/27**	DIGITAL	Corporate	23/02/21	Under Review
Information Sharing Policy	5	**2026/27**	DIGITAL	Corporate	New	New
Information Governance Policy	5	**2026/27**	DIGITAL	Corporate	25/10/18	Under Review
Trust Mobile Phone Policy	5	**2026/27**	DIGITAL	Corporate	01/11/09	Under review

Access Control Policy	5	**2026/27**	DIGITAL	Corporate	25/10/18	Under Review
Information Classification Policy	5	**2026/27**	DIGITAL	Corporate		Under Review
Quality Assurance Framework for the Clinical Desk	5	**2026/27**	OPERATIONS	Clinical	01/06/15	Under Review
Transgender Policy **[?NEW 2026]**	5	**2026/27**	PEOPLE & CULTURE	Employment	New	New

Yes
No

Capacity - CMT
Capacity - Sickness
Capacity - Vacancies
Capacity - Other (please provide details)
Other Reason (please provide details)

Agenda Item No.	13

REPORT TITLE

Losses and Special Payments Payments for the period from 1 April 2025 – 31 January 2026

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	2 March 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Chris Turley, Executive Director of Finance and Corporate Resources
Author(s) of report	Madrun Parry-Jones, Deputy Head of Financial Accounting

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. In accordance with SFI's, this report presents to the Committee details of Losses and Special Payments made during the seven months from 1 April 2025 to 31 January 2026.

2. Total net Losses and Special Payments made were as follows: - 1 April 2025 to 31 January 2026 -£1.979m

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Audit, Risk and Assurance Committee is requested to:

1. Note the Losses and Special Payments Report for this period.

ADDITIONAL PAPER(S)

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

The Audit, Risk and Assurance Committee is requested to receive the following:

Annex 1 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
	N/A

SITUATION

1. In accordance with SFI's all losses and special payments made are to be reported to the Audit, Risk and Assurance Committee on a regular basis.

BACKGROUND

2. This report presents to the Committee details of Losses and Special Payments made during the ten months from 1 April 2025 to 31 January 2026 (Annex 1).

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1 April 2025 to 31 January 2026 amounted to -£1.979m.

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 ten months to 31 January 2026 reimbursements received exceeded payments made by £1.979m.

5. During November 2025 you will note a negative balance of -£0.019m for Damages, this is due to a payment received from BCU regarding their contribution to a claim where the liability split had increased on their side.

6. During December 2025 you will note WRP reimbursements amounted to £0.388m. The vast majority of the reimbursement related to one case amounting to £0.352m, this is in relation to a clinical negligence claim regarding care given to a patient which resulted in the patient dying.

7. During November 2025 and January 2026, 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. Note the Losses and Special Payments Report for this period.

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 January 2026

	£
April 2025	-£1,314,358.67
May 2025	£66,430.59
June 2025	-£649,094.89
July 2025	£85,183.56
August 2025	£18,692.24
September 2025	£64,838.74
October 2025	-£189,746.31
November 2025	£150,253.71
December 2025	-£258,552.21
January 2026	£47,443.59
February 2026	£0.00
March 2026	£0.00
	-£1,978,909.65

Losses and Special Payments Breakdown:

Payment Type	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
	£	£	£	£	£	£	£	£	£	£	£	£	£
Claimants Solicitor Costs	139,680.80	50,036.56	141,100.00	58,600.00	4,318.00	3,200.00	7,972.00	111,664.86	18,050.00	5,349.00	0.00	0.00	539,971.22
Counsel fees	3,570.00	750.00	28,575.00	3,996.45	5,410.00	500.00	3,380.00	7,650.00	3,851.89	312.50	0.00	0.00	57,995.84
CRU	0.00	-2,412.50	5,177.00	913.00	3,636.00	0.00	-1,517.00	-2,892.00	0.00	-169.00	0.00	0.00	2,735.50
Damages	15,375.00	2,241.00	149,910.00	500.00	-19,229.33	22,649.33	40,474.15	-19,773.38	61,500.00	7,876.72	0.00	0.00	261,523.49
Defence Costs	12,678.08	-5,327.38	8,773.00	7,505.53	3,956.46	4,942.83	9,500.00	12,726.25	33,025.00	7,356.71	0.00	0.00	95,136.48
Expert Witness	11,405.00	2,930.00	7,490.00	7,500.00	2,900.00	6,210.00	4,647.80	7,827.00	4,120.00	2,960.00	0.00	0.00	57,989.80
Vehicle Repairs	21,074.64	18,212.91	20,240.59	6,168.58	23,651.11	23,155.08	26,413.30	33,050.98	6,388.65	23,757.66	0.00	0.00	202,113.50
WRP Refund	-1,518,526.19	0.00	-1,020,108.43	0.00	-7,520.00	3,496.50	-282,885.45	0.00	-387,537.75	0.00	0.00	0.00	-3,213,081.32
Property Repairs	395.00	0.00	9,747.95	0.00	1,570.00	685.00	2,268.89	0.00	2,050.00	0.00	0.00	0.00	16,716.84
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**	**£150,253.71**	**-£258,552.21**	**£47,443.59**	**£0.00**	**£0.00**	**-£1,978,909.65**

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	22,960.43	58 Cases
Redress cases < £1000	2,443.00	4 Cases
PI cases < £1000	8,755.00	13 Cases
23RT4MN0014	25.00	
26RT4MN0015	30.00	
26RT4MN0017	30.00	
26RT4MN0006	31.57	
26RT4MN0016	50.00	
26RT4MN0008	58.13	
26RT4MN0007	79.59	
25RT4MN0024	100.00	
26RT4MN0001	130.78	
26RT4MN0009	168.32	
22RT4MN0016	270.00	
25RT4MN0018	913.00	
24RT4GN0020	1,000.00	
24RT4PI0009	1,000.00	
26RT4EG0006	1,000.00	
26RT4EG0011	1,000.00	
26RT4GN0002	1,000.00	
26RT4DP0051	1,077.60	
26RT4EG0014	1,080.00	
26RT4DP0001	1,120.00	
26RT4DP0043	1,214.46	
25RT4EG0024	1,250.00	
26RT4DP0091	1,250.00	
26RT4EG0017	1,250.00	
26RT4EG0029	1,250.00	
26RT4PI0016	1,250.00	
26RT4DP0032	1,259.95	
25RT4MN0022	1,275.00	
26RT4DP0059	1,397.64	
26RT4DP0075	1,438.48	
26RT4DP0004	1,466.54	
24RT4PI0008	1,500.00	
25RT4MN0017	1,500.00	
26RT4DP0093	1,500.00	
26RT4EG0004	1,500.00	
26RT4EG0019	1,500.00	
26RT4EG0025	1,500.00	
26RT4MN0010	1,500.00	
26RT4PI0004	1,500.00	
26RT4DP0060	1,570.00	
22RT4GN0032	1,600.00	
22RT4GN0042	1,600.00	
24RT4GN0040	1,600.00	
24RT4GN0043	1,600.00	
24RT4PI0049	1,625.00	
26RT4DP0062	1,630.00	
24RT4PI0041	1,663.00	
26RT4DP0009	1,668.23	
26RT4EG0038	1,750.00	
26RT4DP0011	1,759.34	
26RT4DP0085	1,776.21	
26RT4DP0082	1,813.39	
26RT4DP0029	1,848.31	
26RT4DP0037	1,875.50	
26RT4DP0102	1,911.67	
23RT4GN0020	1,920.00	
26RT4DP0057	1,928.07	
26RT4DP0106	1,965.85	
26RT4DP0074	1,970.80	
26RT4EG0012	1,996.45	
23RT4MN0021	2,000.00	
26RT4EG0007	2,000.00	
26RT4GN0001	2,000.00	
26RT4DP0100	2,007.97	
26RT4DP0064	2,018.22	
26RT4DP0079	2,021.16	
26RT4DP0097	2,050.00	
26RT4DP0023	2,059.16	
26RT4EG0040	2,180.93	
26RT4DP0006	2,246.39	
26RT4EG0008	2,250.00	
26RT4DP0088	2,268.89	
26RT4DP0077	2,281.72	
22RT4PI0006	2,298.77	
26RT4EG0039	2,350.54	
26RT4EG0003	2,382.05	
26RT4DP0067	2,404.14	
25RT4MN0021	2,430.00	
26RT4EG0028	2,500.00	
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	
26RT4DP0087	2,863.98	
25RT4EG0026	2,950.00	
26RT4EG0020	2,950.00	
23RT4MN0002	2,976.00	
26RT4DP0066	2,978.15	
26RT4EG0032	3,000.00	
26RT4DP0092	3,096.73	
26RT4DP0054	3,106.55	
26RT4DP0022	3,108.53	
26RT4DP0107	3,129.75	
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	
19RT4PI0033	3,428.00	
26RT4EG0015	3,500.00	
26RT4DP0053	3,516.00	
26RT4MN0004	3,740.00	
19RT4PI0034	3,874.00	
26RT4EG0027	4,000.00	
26RT4EG0031	4,000.00	
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	
26RT4DP0096	4,602.55	
26RT4DP0035	4,732.28	
26RT4DP0036	4,756.58	
26RT4DP0055	4,782.03	
26RT4EG0036	4,795.24	
23RT4GN0027	4,800.00	
26RT4EG0033	5,000.00	
26RT4DP0024	5,088.03	
25RT4MN0016	5,136.89	
24RT4PI0047	5,349.00	
26RT4DP0034	5,434.00	
26RT4EG0035	5,500.00	
25RT4EG0035	5,850.00	
25RT4MN0023	5,930.00	
25RT4MN0020	5,992.50	
26RT4DP0080	5,993.80	
24RT4PI0064	6,038.00	
26RT4DP0068	6,482.25	
23RT4GN0013	6,600.00	
22RT4MN0003	6,772.50	
26RT4DP0015	7,294.94	
24RT4PI0045	7,876.72	
26RT4DP0081	8,081.92	
26RT4DP0090	8,868.82	
24RT4PI0066	9,299.80	
23RT4PI0009	9,374.15	
19RT4PI0032	9,546.00	
24RT4PI0028	9,601.00	
24RT4MN0008	10,000.00	
26RT4EG0034	10,500.00	
21RT4PI0026	11,500.00	
25RT4MN0030	13,453.01	
18RT4MN0016	14,632.40	
26RT4DP0046	14,813.66	
26RT4EG0002	18,600.00	
26RT4GN0005	22,000.00	
24RT4PI0060	23,889.48	
24RT4MN0005	24,000.00	
24RT4MN0004	30,000.00	
22RT4PI0046	32,381.16	
22RT4MN0018	37,188.00	
23RT4MN0004	48,225.00	
24RT4MN0013	50,710.00	
24RT4PI0033	83,921.80	
18RT4MN0012	107,779.00	
21RT4MN0009	302,165.00	
24RT4PI0026	- 80.00	REFUND
24RT4GN0040	- 300.00	WRP REFUND
24RT4GN0011	- 300.00	WRP REIMBURSEMENT
24RT4GN0037	- 300.00	WRP REIMBURSEMENT
24RT4GN0031	- 500.00	WRP REFUND
24RT4GN0039	- 500.00	WRP REFUND
24RT4GN0044	- 500.00	WRP REIMBURSEMENT
24RT4GN0038	- 800.00	WRP REFUND
18RT4MN0012	- 829.00	CRU Refund
25RT4MN0018	- 913.00	CRU Refund
23RT4GN0012	- 1,000.00	WRP REFUND
26RT4GN0002	- 1,000.00	WRP REIMBURSEMENT
22RT4GN0042	- 1,100.00	WRP REFUND
26RT4GN0001	- 2,000.00	WRP REIMBURSEMENT
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
22RT4PI0046	- 31,198.01	WRP REIMBURSEMENT
19RT4PI0037	- 38,264.58	WRP REFUND
22RT4MN0002	- 56,500.00	Refund from BCU
24RT4MN0013	- 75,410.00	WRP REFUND
22RT4PI0038	- 89,481.02	WRP REFUND
22RT4PI0022	- 97,409.43	WRP REFUND
18RT4MN0016	- 352,239.74	WRP REIMBURSEMENT
24RT4MN0009	- 961,854.78	WRP REFUND
22RT4MN0001	- 1,450,963.19	WRP REFUND
Total	**- 1,978,909.65**	

Welsh Ambulance Services University NHS Trust
Nov-25

Case Reference	Details	Amount (£)
1334957936	COUNSEL FEES	1,500.00
1334962122	COUNSEL FEES	1,000.00
1335416897	COUNSEL FEES	1,125.00
1334961619	COUNSEL FEES	1,625.00
1335421343	DEFENCE COSTS	1,250.00
1332307550	COUNSEL FEES	250.00
1339144837	EXPERT WITNESS	270.00
1342148752	PROFESSIONAL FEES	175.00
1330558018	EXPERT WITNESS	1,350.00
1332886055	EXPERT WITNESS	4,500.00
1337556457	EXPERT WITNESS	450.00
1341409513	EXPERT WITNESS	50.00
1341408527	COUNSEL FEESS	2,150.00
1341407679	EXPERT WITNESS	476.00
1341407219	EXPERT WITNESS	731.00
1336025568	DEFENCE COSTS	30.00
1330349296	TP VEHICLE REPAIRS	7,447.50
1330558569	TP VEHICLE REPAIRS	493.88
1331103037	TP VEHICLE REPAIRS	1,250.00
1332886526	TRANSCRIPTION SERVICES	123.41
1332362445	TP VEHICLE REPAIRS	3,096.73
1332885609	TRANSCRIPTION SERVICES	97.84
1333921781	TP VEHICLE REPAIRS	1,421.32
1334960210	PROFESSIONAL FEES	900.00
1334961189	TP VEHICLE REPAIRS	500.00
1335413859	PROFESSIONAL FEES	1,500.00
1335416456	PROFESSIONAL FEES	900.00
1335417661	PROFESSIONAL FEES	4,000.00
1336027451	TP VEHICLE REPAIRS	1,500.00
1336028014	TP VEHICLE REPAIRS	160.00
1338029029	PROFESSIONAL FEES	2,500.00
1337557089	TP VEHICLE REPAIRS	280.00
1340192551	PROFESSIONAL FEES	1,250.00
1340813063	TP VEHICLE REPAIRS	11,034.36
1341406533	TP VEHICLE REPAIRS	1,136.84
1341404781	TP VEHICLE REPAIRS	43.80
1342817015	TP VEHICLE REPAIRS	84.00
1342818349	TP VEHICLE REPAIRS	4,602.55
1331103583	CLAIMANT SOLICITOR FEES	377.00
CHEQUE 710730	GENERAL DAMAGES SETTLEMENT	1,600.00
1332882686	CLAIMANTS SOLICITORS FEES	5,262.86
1332968846	GENERAL DAMAGES SETTLEMENT	18,626.62
1332307090	CLAIMANT SOLICITOR FEES	90,000.00
NAT13NOV2509	CRU REFUND	- 2,892.00
NAT19NOV2503	COSTS REFUND FROM BCU	- 26,500.00
NAT19NOV2504	DAMAGES REFUND FROM BCU	- 40,000.00
1341911818	RETURN OF OVERPAYMENT FROM BCU	10,000.00
1338029990	CLAIMANTS SOLICITORS FEES	32,500.00
1340811111	CLAIMANTS SOLICITORS FEES	25.00
Totals		**150,253.71**

Welsh Ambulance Services University NHS Trust
Dec-25

Case Reference	Details	Amount (£)
1352924729	COUNSEL FEES	750.00
1344503509	EXPERT WITNESS	200.00
1344504333	PROFESSIONAL FEES	175.00
1345725402	COUNSEL FEES	901.89
1351767833	PROFESSIONAL FEES	100.00
1345726077	EXPERT WITNESS	3,740.00
1350151092	COUNSEL FEES	1,450.00
1345726893	DAMAGE TO PROPERTY	250.00
1346353801	TP VEHICLE REPAIRS	735.78
1349090177	TP VEHICLE REPAIRS	193.30
1352922317	TP VEHICLE REPAIRS	2,601.60
1352923070	PROFESSIONAL FEES	4,000.00
1352925434	PROFESSIONAL FEES	3,000.00
1353085745	PROFESSIONAL FEES	5,000.00
1353084849	PROFESSIONAL FEES	10,500.00
1353086544	PROFESSIONAL FEES	5,500.00
NAT02DEC2503	WRP REIMBURSEMENT	- 352,239.74
NAT02DEC2503	WRP REIMBURSEMENT	- 31,198.01
NAT02DEC2503	WRP REIMBURSEMENT	- 300.00
NAT02DEC2503	WRP REIMBURSEMENT	- 2,000.00
NAT02DEC2503	WRP REIMBURSEMENT	- 1,000.00
NAT02DEC2503	WRP REIMBURSEMENT	- 500.00
NAT02DEC2503	WRP REIMBURSEMENT	- 300.00
1353083910	GENERAL DAMAGES SETTLEMENT	60,000.00
1350150633	GENERAL DAMAGES SETTLEMENT	1,500.00
1351768849	CLAIMANTS SOLICITORS FEES	50.00
1353829368	TP VEHICLE REPAIRS	850.00
1353824616	CLAIMANT SOLICITOR FEES	18,000.00
1353827792	PROFESSIONAL FEES	4,750.00
1353844192	COUNSEL FEES	650.00
1353843351	TP VEHICLE REPAIRS	2,007.97
CHEQUE NO.710731	DAMAGE TO PROPERTY	1,800.00
1354915004	COUNSEL FEES	100.00
1355496219	EXPERT WITNESS	180.00
Totals		**- 258,552.21**

Welsh Ambulance Services University NHS Trust
Jan-26

Case Reference	Details	Amount (£)
1,360,799,931.00	EXPERT WITNESS	2,960.00
1,360,377,734.00	COUNSEL FEES	312.50
1,360,378,222.00	PROFESSIONAL FEES	30.00
1,360,376,175.00	TP VEHICLE REPAIRS	5,110.00
1,360,377,019.00	TP VEHICLE REPAIRS	2,971.92
1,360,379,193.00	TP VEHICLE REPAIRS	1,911.67
1,360,999,740.00	TP VEHICLE REPAIRS	43.80
1,362,052,791.00	TRANSCRIPTION SERVICES	45.24
1,362,054,536.00	TP VEHICLE REPAIRS	22.00
1,362,545,619.00	TP VEHICLE REPAIRS	452.13
1,363,640,234.00	TP VEHICLE REPAIRS	500.00
1,364,475,043.00	TP VEHICLE REPAIRS	355.60
1,366,664,598.00	TP VEHICLE REPAIRS	7,294.94
1,367,717,291.00	PROFESSIONAL FEE	1,000.00
1,367,717,780.00	TP VEHICLE REPAIRS	1,965.85
1,368,793,916.00	PROFESSIONAL FEE	1,750.00
1,370,535,477.00	PROFESSIONAL FEE	2,350.54
1,370,535,980.00	PROFESSIONAL FEE	2,180.93
1,372,593,621.00	TP VEHICLE REPAIRS	3,129.75
1,372,591,798.00	CRU	744.00
1,362,602,808.00	GENERAL SETTLEMENT FEE	7,876.72
1,372,592,648.00	CLAIMANTS SOLICITORS FEE	5,349.00
NAT02JAN2603	CRU	- 913.00
Totals		**47,443.59**

Agenda Item No.	14

REPORT TITLE

Non-compliance with Standing Orders: publication of late papers

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	2 March 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The Trust's standing orders provision 7.4.8 state that board papers will be made available to the public at least five clear days before each meeting of the board. The Trust extends this provision to the committees in addition to the trust board meetings.

2. The Trust's board and committee secretariat standing operating procedure states that the papers will be published by midday on the seventh day before the meeting. In practice this means that the papers will always be published no later than seven clear days before the meeting.

3. The 2025 Trust Audit Wales Structured Assessment 2025 recommendation one states, "*To strengthen governance and transparency, the Trust should formally record and report any board or committee papers submitted after the five-day publication deadline as a breach of its Standing Orders*". This relates to the finding that the Trust reports non-compliance with standing orders to the Audit, Risk and Assurance Committee (ARAC) and that since the beginning of 2025 there have only been three reported breaches (paragraph 12 of the Structured Assessment).

4. Trust 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, it was the view of Audit Wales that reporting instances of late papers to the ARAC would improve transparency and promote timely submissions.

5. Our management action in response to this recommendation was to report papers published after midday on the seventh day publication date for each meeting. Corporate governance maintains a log which records publication of late papers. Since 01 January 2026 there have been nine papers recorded as late as detailed in appendix one.

6. Where late papers are received it is the Chair of the Trust Board or the particular Committee who provides approval to its late upload. Papers listed in appendix one were known to be expected late prior to the seven day deadline and this was communicated to the respective chairs.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The committee is requested to:

1. Receive and note the report of non-compliance with standing orders in regard to publication of late papers from 01 January 2026-20 February 2026.

ADDITIONAL PAPER(S)

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

n/a

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document here for further details.	
Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

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

Appendix 1:

Meeting	Meeting Date	Item	Paper Title	Days Late
Charity Committee	13-Jan-26	13	Risk Management Report and BAF	2
FPC Open	20-Jan-26	8	Monthly Integrated Quality Performance Report	4
FPC Open	20-Jan-26	11.2	Integrated Medium Term Plan (IMTP) 26-29 Development Update, Including Financial Plan 2026/27	2
FPC Open	20-Jan-26	12	Fire Safety Report	2
FPC Closed	20-Jan-26	6	(ProQA) Medical Priority Dispatch System (MPDS) Contract Award - Recommendation Report	5
Trust Board Open	29-Jan-26	9	Actions to Mitigate Avoidable Patient Harm (revised narrative regarding modelling approach)	4
Corporate Trustee	29-Jan-26	5	2026/27 Fundraising Targets and Expenditure Budget	3
Trust Board Open	29-Jan-26	11	Monthly Integrated Quality Performance Report	4
Trust Board Closed	29-Jan-26	9	FPC Highlight Report Closed meeting 20 January 2026	4

Agenda Item No.	15

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 March 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	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, which now includes reporting against non-compliance against standing orders with regard to publication of late papers, and that the first report will be presented at this meeting.

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.	• This committee will review its own quality and governance at the March 2026 meeting. • In December 2025 the committee considered the options for the wider board committee framework changes and endorsed 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 March 2026.

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
N/A

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document here for further details.	
Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
N/A	N/A

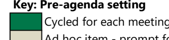
PAPER	PRE or POST C'EE FORUM	FREQUENCY	Q1a	Q1b	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
AUDIT, RISK AND ASSURANCE COMMITTEE - CYCLE OF BUSINESS 2025/26										
For the rationale for this Committee's cycle see Note 8										
Annual filings										
Annual accounts planning and emerging issues report	ELT	Annually						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 losses 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.