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

Agenda attachments

00 Agenda 02092025

OPENING ITEMS

1 09:30 - Chair's Welcome, Apologies and Quorum

2 Declarations of Interest

02 Board Member Register of Interests - Updated 22 August 2025

3 Minutes of the Last Meeting: 24 June 2025

Item 03 2025-06-24 ARAC OPEN Minutes unconfirmed

4.1 Action Log & Matters Arising

Item 04.1 Action Log open agenda

4.2 Committee AAA Report: 24 June 2025

Item 04.2 Audit Committee AAA Report 24 June 2025

4.3 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:35 - Standing Financial Instructions Changes: Social Partnership & Public Procurement Act (2023)

The following Annexes to accompany this paper are available in the Reading Room:
Annex 1 Welsh Health Circular
Annex 2 Updated Chapter 11 as issued by Welsh Government
Annex 3 Tracked Changes to Chapter 11

Item 05 Executive Summary SBAR Procurement Act 2023

6.1 09:50 - Internal Audit Progress Report

Item 6.1 Internal Audit Progress Report

6.2 Internal Audit Reports

Item 6.2.1 Manchester Arena Inquiry Internal Audit Report
Item 6.2.2 Organisational Change internal Audit Report

Item 6.2.1 Manchester Arena Inquiry Internal Audit Report

Item 6.2.2 Organisational Change Internal Audit Report

6.3 Proposed Amendment to the 2025/26 Internal Audit Plan

Item 06.3 Proposed Change to 2025-26 Internal Audit Plan

7 10:50 - Audit Wales Update Report

Item 07 Audit Wales Update Report

7.1 11:05 - COMFORT BREAK

8 11:20 - Risk Management and Board Assurance Framework

There is a further BAF document available to view in the Reading Room

Item 08 Executive Summary Risk Management Report ARAC 020925

Item 08 Annex 4 - Trending Data - March 2023-July 2025

8.1 Risk Management Policy

Item 08.1 Risk Management Policy

9 11:35 - 2025/26 Effectiveness Reviews, including progress from Part II 24/25 Review

Item 09 ARAC Briefing on Effectiveness Review 2025-26

10.1 11:45 - Integrated Governance Programme Report

Item 10.1 Integrated Governance Programme Report

Item 10.1 Annex 2 Board and committee report writing v.02 080825

Item 10.1c Annex 3 2025 front cover - short form report

Item 10.1d Annex 4 2025 front cover and SBARN

10.2 Mid Year Review of Changes to Committee Operating Arrangements

Item 10.2 Mid-year review of operating arrangements

Item 10.2 Annex 1 Changes to board and committee operating arrangements 2025-26

11 12:00 - Audit Tracker 2025-2026 Q1

Annexes to the Tracker are available to view in the Reading Room

Item 11 Audit Tracker 25-26 Q1 (Apr-Jun25) Updates

12 12:10 - Policy Report (bi-annual)

Item 12 Executive Summary Policy Report

13 12:20 - Assurance to ARAC on Speaking Up Safely Framework (from Chair of People and Culture Committee)
Item 13 Speaking Up Safely Assurance from PCC Chair

14 12:25 - Assurance to ARAC on Near Miss and Low Harm Intelligence Framework (from Chair of QuEST Committee)
Item 14 Near Miss and Low Harm Incident Reporting position from QuEST Chair 110825

15 12:30 - Losses and Special Payments
Item 15 Executive Summary SBAR Losses and Special Payments - Sept ARAC
Item 15 Annex 1 - Losses Special and Payments 2025-26

15.1 CONSENT ITEMS

16 12:40 - Cycle of Business Monitoring Report and Priorities Update 2025-26
Item 16 ARAC Priorities and Cycle Monitoring Report - September 2025
Item 16 Annex 1 Tab 1
Item 16 Annex 1 Tab 2

17 All Wales Audit Committee Chair's Annual Report 2024/25
Item 17 Annual Report AWACC 2024-2025 pdf

18 Joint Directorate Notice (Ref:006-25)
Item 18 006-25 Joint CorGov FinCoR Notice - Contract Management (150725)

18.1 CLOSING ITEMS

19 12:45 - Reflections and Summary of Decisions/Actions

20 Any Other Business

21 Date & Time of the Next Meeting: 2 December 2025

Length of Meeting:	03:20	Agenda Status:	[OPEN] AUDIT, RISK AND ASSURANCE COMMITTEE - 2 SEPTEMBER 2025					Deadline for Papers: 22 AUGUST 2025		Last good practice Exec Review: 20 Au
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**	**Further approval route (if app.)**
			OPENING ITEMS							
		1	Chair's Welcome, Apologies and Quorum	Verbal	Information	Standing	n/a	Chair	n/a	
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a	
09:30	00:05	3	Minutes of the Last Meeting: 24 June 2025	Paper	Approval	Standing	n/a	Chair	n/a	
		4	Action Log & Matters Arising: 4.1 Action Log 4.2 Committee AAA Highlight Report: 24 June 2025	Paper	Discussion	Standing	n/a	Chair	n/a	
			FOR APPROVAL, ASSURANCE AND DISCUSSION							
09:35	00:15	5	Standing Financial Instructions Changes: Social Partnership & Public Procurement Act (2023)	Paper	Endorsement	Forward Planner	CorGov	Chris Turley	Jessica Price	Trust Board for approval, 250925
09:50	01:00	6	6.1 Internal Audit Progress Report 6.2 Internal Audit Reports: 6.2.1 Manchester Arena Inquiry (MAI) (Peter Brown/Elliot Miller) 6.2.2 Organisational Change Policy (OCP) (Carl Kneeshaw) 6.3 Proposed Amendment to the 2025/26 Internal Audit Plan (Trish Mills)	Paper	Assurance	CoB	Internal Audit	Osian Lloyd	Felicity Quance	
10:50	00:15	7	Audit Wales Update Report	Paper	Assurance	CoB	External Audit	Fflur Jones	n/a	
11:05	00:15		COMFORT BREAK							
11:20	00:15	8	Risk Management and Board Assurance Framework	Paper	Assurance	CoB	CorGov	Julie Boalch	n/a	
		8.1	Risk Management Policy	Paper	Endorsement	CoB	CorGov	Julie Boalch	n/a	
11:35	00:10	9	2025/26 Effectiveness Reviews, including progress from Part II 24/25 review	Paper	Assurance	ASM	CorGov	Trish Mills	Julie Boalch, Alex Payne	
11:45	00:15	10.1	Integrated Governance Programme Report	Paper	Assurance	Forward Planner	CorGov	Trish Mills	Julie Boalch, Alex Payne	
		10.2	Mid Year Review of Changes to Committee Operating Arrangements	Paper	Assurance	CoB	CorGov	Trish Mills	Julie Boalch, Alex Payne	
12:00	00:10	11	Audit Tracker 2025/26 Q1	Paper	Assurance	CoB	CorGov	Trish Mills	Lisa Trounce	
12:10	00:10	12	Policy Report (Bi-annual)	Paper	Assurance	CoB; Planner	Gov	Julie Boalch	Lisa Trounce	
12:20	00:05	13	Assurance to ARAC on Speaking Up Safely Framework (from Chair of People and Culture Committee)	Paper	Assurance	CoB	Gov	Ceri Jackson, Trish Mills	Alex Payne, Sarah Harland	
12:25	00:05	14	Assurance to ARAC on Near Miss and Low Harm Intelligence Framework (from Chair of QuEST Committee)	Paper	Assurance	CoB	CorGov	Bethan Evans, Trish Mills	Alex Payne, Sarah Harland	
12:30	00:10	15	Losses and Special Payments	Paper	Assurance	CoB	FinCor	Chris Turley, Ed Roberts	Jessica Price	
			CONSENT ITEMS							
		16	Cycle of Business Monitoring Report and Priorities Update 2025-26	Papers	Information	CoB	CorGov	Trish Mills	Sarah Harland	
12:40	00:05	17	All Wales Audit Committee Chair's Meeting Report 2024-2025	Verbal	Information	ASM	n/a	Chair	Alex Payne, Sarah Harland	
		18	Joint Directorate Notice (Ref:006-25) **[To be noted this was an action for the Contract Management Advisory and is here for information]**	Verbal	Information	Ad Hoc	CorGov	Trish Mills	n/a	
			CLOSING ITEMS							
		19	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a	
12:45	00:05	20	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a	
		21	Date & Time of the Next Meeting: 2 December 2025	Verbal	Information	Standing	n/a	Chair	n/a	
12:50	**03:20**		**CLOSE**							

LEAD PRESENTERS

Name	Position
Julie Boalch	Assistant Director of Governance and Risk
Peter Curran	Non-Executive Director and Committee Chair
Bethan Evans	Non-Executive Director and Chair of the Quality Patient Experience and Safety Committee
Ceri Jackson	Non Executive Director, Vice Chair of Trust Board and Chair of People and Culture Committee
Fflur Jones	Audit Wales
Osian Lloyd	Head of Internal Audit
Trish Mills	Director of Corporate Governance/Board Secretary
Chris Turley	Director of Finance

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	**Non-Executive Director** * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1985		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	**Non-Executive Director** * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
BROOKS, Lee	**Executive Director of Operations**	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
CURRAN, Peter	**Non-Executive Director** * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022	17 July 2025	
		Chair - Taff Housing Association	Any Other Interest	17 July 2025		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022	31 October 2024	
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024		
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015	January 2025	
		Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director - Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Chair - North Devon Homes	Position in Charity or Voluntary Organisation	01 October 2021	January 2025	
		Company Director - North Devon Homes	Directorships	01 April 2022		
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Chief Executive Officer (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at Beacon Housing (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Moorlands Property Ltd	Directorships	16 August 2022		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		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		
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
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		
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KILLENS, Jason	**Chief Executive**	Honorary Professor - Swansea University	Personal or Departmental Sponsorship	2019	31 May 2025	18 July 2025
		Emeritus Professor - Swansea University	Non-Financial Professional	31 May 2025		
		Chairperson – Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	September 2024		
		Company Director of the Association of Ambulance Chief Executives (AACE), Co No. (07761209)	Directorships	September 2024		
		Officer of the Order of St John	Any Other Interest	January 2024		
		Member of the Order of St John	Any Other Interest	2009	2024	
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
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		
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	**Trade Union Partner**	Nil Declaration				
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		
		Vice Chair - Royal College of Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	03 February 2025		

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

MINUTES OF THE OPEN MEETING OF THE AUDIT, RISK AND ASSURANCE COMMITTEE OF THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST HELD ON TUESDAY 24 JUNE 2025 IN CARDIFF MRD AND VIA TEAMS

Meeting Commenced at 09:45

PRESENT:

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

IN ATTENDANCE:

Jason Killens	Chief Executive Officer (Item 13)
Hugh Bennett	Assistant Director, Commissioning & Performance (Item 5.2.3)
Julie Boalch	Assistant Director of Corporate Governance and Risk
Judith Bryce	Assistant Director of Operations
Christian Fox	Trade Union Partner
Fflur Jones	Audit Wales
Sarah Harland	Corporate Governance Officer
Wendy Herbert	Assistant Director of Quality and Nursing
Osian Lloyd	Head of Internal Audit, NWSSP
Amy Lord	Audit Wales (Item 13)
Trish Mills	Director of Corporate Governance/Trust Board Secretary
Jason Killens	Chief Executive Officer (Item 13)
Carl Kneeshaw	Director of People
Alex Payne	Corporate Governance Manager
Jessica Price	Head of Financial Accounting
Felicity Quance	Deputy Head of Internal Audit, NWSSP
Ed Roberts	Interim Deputy Director of Finance
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner
Yvonne Thomas	Audit Wales (Item 13)
Carl Window	Local Counter Fraud Manager

APOLOGIES:

Christian Fox	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

1. WELCOME, APOLOGIES AND QUORUM

1.1 The Chair warmly welcomed everyone to the meeting of the Audit Risk and Assurance Committee (ARAC). The Chair thanked everyone who contributed to the reports, acknowledging the excellent standard of work.

1.2 Apologies were received from Christian Fox and Liam Williams, and it was acknowledged Wendy Herbert would be deputising in Liam absence.

1.3 Sarah Harland was welcomed in her capacity of the new Corporate Governance Officer providing secretariat support to the Audit Risk and Assurance Committee moving forward.

1.4 It was confirmed the meeting was Quorate.

The Committee RESOLVED to:

(1) Noted the apologies from Christian Fox and Liam Williams, and it was acknowledged Wendy Herbert would be deputising in Liam absence.

(2) Noted Sarah Harland's role as the new Corporate Governance Officer providing secretariat support to the Audit Risk and Assurance Committee moving forward.

2. DECLARATIONS OF INTEREST

2.1 For transparency and to avoid any potential conflicts of interest, the Chair advised of a change in status at Kaplan International College, he is now a substantive member of the governing body. Trust Board, rather than an interim member, and was congratulated by the Committee for this.

2.2 There were no further declarations of interests recorded other than those listed on the Register of Interests.

The Committee RESOLVED to: Noted the Chair's change in status at Kaplan International College, and that there were no further Declarations of Interests recorded other than those listed on the Register of Interests.

3. MINUTES OF THE LAST MEETING 01 MAY 2025

2.3 The Minutes of the ARAC held on 01 May 2025 were approved.

The Committee RESOLVED to: Approved the Minutes of 01 May 2025.

4.1 ACTION LOG AND MATTERS ARISING

4.1.1 ***Action 20/25*** *01 May 2025 Annual Trust Board and Committee Effectiveness Review 2024/2025 (All Committees) Ceri Jackson requested further details on the governance process in terms of EqIA's. It was agreed that Trish Mills would provide further guidance on the completion of EqIAs as a substantive item at the next meeting.* Trish Mills provided an update on the Equality Impact Assessment (EQIA) process. The goal is to integrate impact assessments early in strategy or policy development to highlight their value. New

document front covers now include a section asking if an impact assessment is required, with hyperlinks to relevant documents. There was a discussion about incorporating the Well-being of Future Generations Act into the impact assessments, aiming to embed long-term considerations. The importance of conducting these assessments properly was emphasised, with a suggestion to review their effectiveness next year.

The Committee RESOLVED to: Noted the update on the actions as described.

4.2 COMMITTEE AAA REPORT

4.2.1 The Committee AAA report dated 01 May 2025 was received.

The Committee RESOLVED to: Noted the AAA Report of 01 May 2025.

5. INTERNAL AUDIT REPORTS

5.1 ANNUAL HEAD OF INTERNAL AUDIT OPINION 2024/25

5.1.1 Osian Lloyd presented the 2024/25 Annual Internal Audit Opinion, which concluded with a reasonable assurance rating. The report confirmed that 20 reviews were completed, two with substantial assurance, 13 reasonable, four limited and one advisory. The Internal Audit Plan was delivered as agreed, and all service performance indicators presented as green by year end; which reflects strong collaboration between Internal Audit and management within the Trust. The Committee was assured that sufficient work had been undertaken to support the opinion, which contributes to the Board's understanding of Governance, Risk Management and Internal Control.

5.1.2 The Chair acknowledged the improvement in Performance Indicators and confirmed that the one outstanding report had already been factored into the Annual Opinion. Trish Mills noted that she has recently introduced a new template to support Equality Impact Assessments (EqIAs), which encourages early engagement and highlights links to Data Protection and Environmental Impact Assessments. Trish also highlighted efforts to align with the Wellbeing of Future Generations Act.

5.1.3 Rhiannon Beaumont-Wood raised the need for a more strategic approach to patient experience and community involvement. Wendy Herbert confirmed a Strategic Plan is in place, supported by a new Service User Framework and Action Plan, with internal delivery under review to better reflect patient voice.

The Committee RESOLVED to:

(1) Noted The 2024/25 Head of Internal Audit Opinion.

(2) Members were reasonably assured that sufficient audit work was undertaken during the year to be able to give an overall Opinion in line with the requirements of the Public Sector Internal Audit Standards.

5.2 INTERNAL AUDIT REPORTS

5.2.1 The following Internal Audits were completed during the quarter and presented to the Committee. Members reviewed the management actions that accompanied the Audits and were assured they were appropriate and timely. There is one review that was slightly delayed (111 Wales Website) which is in draft format and will be presented to the next meeting.

5.2.1 Follow Up Audit on 2024/2025 (reasonable assurance)

5.2.1.1 Felicity Quance presented the Follow-Up Audit Report, confirming that all 18 tested recommendations were correctly marked as complete, despite some requiring additional evidence. The Trust's Q3 2024/25 closure rate of 67.9% exceeds the All-Wales average of 65.1%. A new approach will see follow up audits conducted quarterly rather than annually.

5.2.1.2 The Trust is trialling a new Tracker system with Digital Health and Care Wales, and a Counter Fraud Tracker, launched in April, and will be reviewed at the next ARAC Committee meeting. Trish Mills praised the work of Alex Payne and Lisa Trounce in progressing closures and stressed the importance of timely and well evidenced action completion. Carl Window suggested biannual updates for the Counter Fraud Tracker but agreed to present it quarterly if preferred.

5.2.2 Contract Management Advisory Report (no assurance rating applied)

5.2.2.1 Felicity Quance presented the all-Wales advisory review on Contract Management, which identified six common improvement areas across NHS organisations. The Trust was the only body with a Contract Register in place, although still developing. Due to resource constraints, a centralised register will not be pursued, and directorate level registers will be maintained instead. Strong practices were acknowledged in high-risk areas such as Digital and Finance & Corporate Resources Directorates.

5.2.2.2 Chris Turley welcomed the report, acknowledging the timing challenges and the need to strengthen Contract Management culture. Chris referenced the joint Siren Notice and governance note to be issued to reinforce responsibilities. Trish Mills acknowledged the importance of the report and emphasised the need for improvements within contract management processes, highlighting the significance of addressing the recommendations provided in the report to enhance the overall efficiency and effectiveness of contract management within the organisation.

5.2.2.3 Carl Window raised concerns about relying solely on managers to uphold contract responsibilities and the missed opportunity of a centralised register, particularly for managing procurement fraud risk. Carl questioned how awareness and compliance would be measured. Felicity Quance confirmed the topic will remain on the agenda and stated that many staff already have Contract Management duties embedded in their roles. ARAC agreed to revisit progress in nine months.

5.2.3 Seasonal Modelling and Forecasting (reasonable assurance)

5.2.3.1 Felicity Quance presented the audit focused on winter resilience planning. There were seven medium priority findings. Key issues included weak documentation, unclear ownership and the absence of a formal post implementation review or evaluation against IMTP priorities. The Forecasting and Modelling Group, established during COVID-19, is now permanent but requires clearer Terms of Reference and stronger meeting administration.

5.2.3.2 Hugh Bennett acknowledged the findings, noting strong culture but limited process capacity, and welcomed the audit's insights. He and Trish Mills agreed that the actions outlined will help build a more robust framework. Rhiannon Beaumont-Wood and Ceri Jackson stressed the need for appropriate tools and clarity on capacity. The Chair raised concerns about assurance and feasibility based on the comments from Hugh Bennett; which prompted request for Hugh to revisit capacity discussions with Rachel Marsh, the Executive owner of this audit and the related management actions

5.2.2.3 Chris Turley cautioned against discussing resourcing in this forum and emphasised managing within existing budgets. Hugh Bennett agreed and proposed further discussion outside the meeting. The Committee noted that the need for formal evaluation is a recurring audit theme and asked the Finance and Performance Committee, who will receive the report in July, to consider its role in overseeing such evaluations. Further clarity on capacity will be revisited in September.

5.2.4 Start of Shift Procedure (limited assurance)

5.2.4.1 The Committee reviewed the Start of Shift Procedure Report, which assessed compliance with the SOP covering vehicle preparation and equipment availability. While vehicle checks are being completed, the audit found limited evidence of consistent recording and reporting, largely due to operational pressures and time constraints. Four of six objectives were rated as reasonable or substantial, with three rated limited, and five management actions were raised.

5.2.4.2 To address the findings, the existing Vehicle Accident Management Task and Finish Group will expand its scope to develop a more efficient system for recording checks and update the SOP accordingly. Judith Bryce and Rhiannon Beaumont-Wood supported the changes, highlighting the need for improved evidence and accessibility. Damon Turner linked the challenges to wider system pressures, including hospital delays. The Committee welcomed the assurance that progress will be monitored through the Senior Operations Team and reported to the Senior Leadership Team.

5.2.5 Emergency Communications Nurse System Implementation (reasonable assurance)

5.2.5.1 The Committee reviewed the Emergency Communications Nurse System Implementation Audit (ECNS), which received a reasonable assurance rating. Three objectives were rated reasonable and two limited, with key issues including a backlog of over 400 audits, limited clinician monitoring and no post-implementation review. The absence of formal

evaluation and escalation processes could impact accreditation. These findings reflect a broader theme seen in previous audits, highlighting the need to pause and assess project outcomes.

5.2.5.2 Management acknowledged the issues and confirmed that the onboarding of six new auditors in Q2, along with improved processes, will help address them. Judith Bryce and Wendy Herbert highlighted progress since 2021 and confirmed that most expected benefits were realised, though a full evaluation is still needed. Felicity Quance and Osian Lloyd emphasised the importance of structured benefits realisation across projects. Oversight of the audit actions sits with the Finance and Performance Committee, which will receive the report in July. ARAC has asked the Committee to further consider its role in monitoring post implementation evaluations across the Trust.

5.2.6 Capital Systems (reasonable assurance)

5.2.6.1 Felicity Quance presented the Capital Systems Internal Audit Report, which received a reasonable assurance rating. While most controls were effective, the audit identified one high and four medium priority findings. These included undocumented procedures, issues with contract management, and non-compliance with Declarations of Interest, particularly involving NWSSP Procurement Officers. Chris Turley welcomed the assurance level but expressed concern over potential delays in contract signing due to one of the recommendations and called for a pragmatic application of this, if required. Chris confirmed the Trust had already fulfilled its responsibilities within the required management action, including sharing the findings with NWSSP to support compliance improvements.

The Committee RESOLVED to:

(1) Noted the following Internal Audit reports: Follow Up Audit 2024/25; Contract Management Advisory Report; Seasonal Modelling and Forecasting; Start of Shift Procedure. Emergency Nurse Communications System Implementation; and Capital Systems.

(2) It was agreed that the Committee schedule a follow up to the Contract Management Advisory Report in 6-9 months' time, to ensure that the suggested actions in the report, particularly those involving shared services are being addressed.

(3) Seasonal Modelling and Forecasting - Hugh Bennett to discuss with Rachel Marsh and clarify position and resource requirements.

6. AUDIT WALES REPORTS

6.1 Audit Wales Update Report

6.1.1 Fflur Jones provided an update on the Performance Audit, stating that the completed Urgent and Emergency Care Review was included in the update. Fflur added that fieldwork for the Structured Assessment and Deep Dive would begin shortly, with fieldwork for Estates and the local review scheduled to start later in the year.

6.1.2 Trish Mills stated that the Audit Wales Cost Saving Arrangements Checklist – a Checklist for NHS Board Members has been added to the Trust Board Induction Pack and would be circulated to the Non-Executive Directors. Trish also added that Estelle Hitchon is reconvening the Task and Finish Group in September to work on operationalising the Wellbeing objectives, using the framework from the Wellbeing of Future Generations Report.

The Committee RESOLVED to:

(1) Received the Audit Wales update report.
(2) Noted The 2025/26 Structured Assessment brief has been agreed and work is underway, with the deep dive for 2025/26 being a review of the arrangements to manage estates (due to be reported in March 2026).
(3) Noted The 2024/25 deep dive review of investment in digital systems to support service resilience and transformation is due to be reported to ARAC in November, using it as a framework to re-convene the Task and Finish group in September.
(4) The Committee agreed that an action would be taken by Trish Mills to circulate the Cost Saving Arrangements Checklist – A Checklist for NHS Board Members, to the Non-Executive Directors. The Committee noted that the Audit Wales Checklist is included within the Trust Board Induction Pack.

6.2 Urgent and Emergency Care Report

6.2.1 Fflur Jones presented the Urgent and Emergency Care Report, highlighting the Trust's efforts to manage demand through community based care and reduced hospital transportation. Despite progress, issues such as handover delays, inconsistent access to services and fragmented data persist. Fflur advised that she provide a realistic date for the completion of the National View Report on Collaboration Handover between organisations.

6.2.2 The 111 Wales Website needs urgent updates, and collaboration with Health Boards must improve. Ceri Jackson emphasised better communication, data integration and public engagement. The Committee requested follow up on the National View Report on Collaboration Handover and clarification on the "no send" approach.

6.2.3 The report examined Urgent and Emergency Care in three parts: flow out of hospital (not applicable to the Trust), accessing urgent and emergency care, and national arrangements and leadership structures.

6.2.4 The Committee acknowledged the Trust's positive changes but stressed the need for collaboration with Health Boards to address systemic challenges and improve patient outcomes. The Committee expressed concern about patients harmed by handover delays and the need for urgent action and acknowledged the need for a formal engagement plan and integrated data to improve patient pathways. The Committee also

acknowledged Health Boards legal responsibility to trigger the Duty of Candour for patients harmed by handover delays and suggested using available data for future audits.

The Committee RESOLVED to:

(1) Took assurance from the Urgent and Emergency Care Review
(2) Fflur Jones to provide a realistic date for the completion of the National View Report on Collaboration Handover between organisations.
(3) Fflur Jones to double check the report's reference to the "no send" approach and confirm whether it accurately reflects the current status.

7. RISK MANAGEMENT REPORT

7.1 The Committee received the 2025/26 Risk Report, confirming no material changes to principal risks. Discussion focused on the repositioning of Risks 223 and 224, separating internal and external controls and introducing effectiveness scoring. This new approach, already improving discussions on Risk 223, may be applied to other such as the Decarbonisation Risk.

7.2 Risk appetite statements are being finalised, and a strategic Board Assurance Framework is in development. Julie Boach reported that interviews for a new Risk Manager are scheduled for 11 July with the aim of supporting the enterprise Risk Management Programme and to explore Digital Solutions for Risk Management as key pieces of work within their role.

7.3 New dashboards have been developed, and the Committee supported flexibility in the work programme timings as new processes are tested.

The Committee RESOLVED to:

(1) Consider and discuss the contents of the Report.
(2) Received assurance on progress of the 2025/26 work programme and timelines.
(3) Noted the development of Risk Appetite Statements.
(4) Noted the next steps in relation to a Digital Risk Management solutions.
(5) Received assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant Committees.
(6) Noted the ratings and mitigating actions for each principal risk.

8. AUDIT TRACKER UPDATE - Q4 2024/25 T

8.1 The Committee acknowledged strong Q4 progress on the Audit Tracker, with 51% of internal and 85% of external audit actions closed. Four ePCR audit actions, now under the Digital Directorate, remain open but are being actively addressed following a recent review. Trish Mills and Osian Lloyd confirmed a phased approach to the implementation of recommendations from the audit, which involves prioritising and addressing the recommendations in stages to ensure a manageable and effective implementation process. i, with further detail to be shared at the next meeting.

The Committee RESOLVED to:

(1) Noted the progress made in closing audit actions in Quarter 4.

(2) Noted the ELT's decision to remove the option of a third revised deadline

(3) Received assurance that the management actions for the audits within the purview of this Committee (at Annex 1), and overall (at Annex 2), are being effectively and appropriately managed, closed off in quarter or clarity provided on dates which have moved and rationale.

(4) It was agreed a detailed progress update on the Electronic Patient Clinical Records (ePCRs) actions will be scheduled for the Committee's September 2025 Forward Planner.

9. LOSSES AND SPECIAL PAYMENTS

9.1 The Committee reviewed the Losses and Special Payments Report, which included full year data for 2024/25 and early figures for 2025/26. Total net losses for 2024/25 were £0.668 million, and -£1.248 million for April/May 2025. Chris Turley confirmed the report was standard and accurate, and the Chair expressed satisfaction. The Committee emphasised the importance of learning from these incidents and maintaining strong processes to prevent future losses.

The Committee RESOLVED to:
Noted the Losses and Special Payment Report for 1 April – 31 May 2025.

10. NHS WALES NO PO NO PAY POLICY

10.1 Edward Roberts presented revisions to the NHS Wales No PO No Pay Policy, including a new minimum exception list, updated objectives referencing late payment fees and removal of escalation tables to allow local processes. The policy will go to the Finance and Performance Committee for approval. Trish Mills clarified that while the ARAC can't approve financial policies, it can approve financial procedures and advised that the terms of reference for ARAC would be updated to ensure that the governance route for such business was clear.

The Committee RESOLVED to:

(1) The Committee received and accepted the changes to the national Policy;

(2) Noted that the Policy is to go to the Finance and Performance Committee for Approval.

11. INTEGRATED GOVERNANCE PROGRAMME

11.1 Trish Mills highlighted key aspects of the Integrated Governance Programme. In Q1, standardised templates will be launched on 1 August, followed by a six-month review. Q2 will focus on a meeting etiquette policy and minute formatting. Q3 will introduce an assurance and accountability handbook, while Q4 will explore AI tools, with some elements continuing into the next year. Trish emphasised the goal of embedding good Governance throughout the organisation.

11.2 In response to the Chair's question about resourcing, Trish Mills acknowledged constraints but noted that efforts were concentrated on high impact initiatives. Rhiannon Beaumont-Wood supported the programme's ambition, urging it to be seen as an enabler. Trish agreed, stressing the importance of communicating benefits. Ceri Jackson emphasised accessibility compliance, and Trish confirmed that feedback is being gathered, with Julie Boach and Alex Payne leading the consultation.

The Committee RESOLVED to:
Received assurance on progress of the programme and noted the timelines for the 2025/26 deliverables.

12. NON-COMPLIANCE WITH STANDING ORDERS

12.1 Trish Mills reported an internal oversight in authorising an Employment Tribunal settlement due to a misinterpretation of financial tables. The Remuneration Committee has since approved it retrospectively and the position will be reported to the Trust Board. Carl Kneeshaw clarified that the wrong delegation criteria were applied; the payment should have followed the ex-gratia process, requiring approval from the Chief Executive, Remuneration Committee and Welsh Government. Carl assured the Committee that future cases will follow the correct procedure.

The Committee RESOLVED to:

(1) Noted the position with non-compliance against Standing Order and mitigating actions taken regarding the non-compliance reported to the Remuneration Committee in June 2025.
(2) Noted that the Trust Board will be notified via the ARAC AAA report.

13.1 2024-25 ANNUAL ACCOUNTS, ANNUAL REPORT AND RECOMMENDATIONS TO TRUST BOARD

13.1.1 <u>2024-25 Annual Audit Accounts</u>

The Chair expressed gratitude to the staff for their work on the Annual Report and Accounts, emphasising the high standard necessary for Audit Wales scrutiny and approval. Chris Turley highlighted key points from the Annual Accounts, noting that the official deadline for NHS bodies certified accounts is the end of the month, earlier than last year. Draft accounts were submitted by 2 May, showing a surplus of £70,000 for the year. Income for the year was just over £325 million, reflecting significant growth, and expenditure nearly matched income, resulting in the £70,000 surplus. The accounts included compliance with the public sector payment policy and a capital element.

13.1.2 Amy Lord summarised the audit findings, stating an unqualified audit opinion is intended, subject to the signed Letter of Representation. No significant issues or uncorrected misstatements were found, and improvements from the previous year were noted. The Auditor General is expected to sign the accounts on 27 June, ahead of the 30 June deadline. Jason Killens expressed pride in the Finance Team's work and emphasised the significance of securing a clean audit opinion, given the organisation's growth. The Chair

praised Audit Wales for their pragmatic approach and to the Finance Team for their professionalism and competence.

13.1.3 The following formalities were undertaken:

- The Audit Risk and Assurance Committee endorsed the Trust's Annual Accounts 2024/25 for approval by the Trust Board on 26 June.
- The Letter of Representation, the Appendix to the Audit Report, was also endorsed by the Committee for signature on 26 June by Jason Killens and the Chair.

13.2 <u>2024-25 Annual Report</u>

13.2.1 Trish Mills presented the draft Annual Report, comprising the respective Performance and Accountability Reports developed in line with the Manual for Accounts. The report has been reviewed by the Trust Board, with feedback from Audit Wales and Welsh Government addressed. While the Duty of Quality Report was presented separately, Quality Governance is referenced. Final updates are pending, including the Auditor General's Opinion and the Remuneration Table, with the Statement of Directors' Responsibilities to be signed post-approval.

13.2.2 Ceri Jackson praised the report's clarity and balance, suggesting a shorter, easy-read version to improve accessibility and public engagement. Trish Mills agreed, highlighting its value to stakeholders such job applicants and the effort involved in translation. This will be considered for the 2025-26 annual report preparation.

13.2.3 Rhiannon Beaumont-Wood supported the idea of an easy read version and recommended highlighting partnership impacts and sharing content with partners to ensure collaboration. Trish Mills confirmed flexibility in content, though some elements are prescribed, and highlighted the challenge of balancing design and translation resources.

13.2.4 The Chair confirmed the Audit Risk and Assurance Committee's endorsement of the report for Trust Board approval.

The Committee RESOLVED to:

(1) Endorsed the Trust's Annual Accounts 2024/25 for formal approval by the Trust Board at its meeting on 26 June 2025.

(2) Endorsed the Letter of Representation, the Appendix to the Audit Report, for signature on 26 June by Jason Killens.

(3) Endorsed the 2024-25 Annual Report for formal approval by the Trust Board at its meeting on 26 June 2025.

14. COMMITTEE MONITORING REPORT AND PRIORITIES UPDATE 2025-26

14.1 The Committee's Cycle of Business Monitoring Report and Priorities update were received.

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

15. REFLECTIONS

15.1 The Committee acknowledged the high standard and quality of work and presentations, reflecting the professionalism and dedication of the staff involved. The Committee emphasised the importance of collaborative effort and the professionalism demonstrated by all participants, highlighting the effective teamwork across different roles and departments. Members acknowledged the difficulty in achieving a balance between detail and conciseness in the reports and congratulated all contributors for striking this balance effectively, making the reports both comprehensive and accessible.

16. ANY OTHER BUSINESS

16.1 None

17. Date of next meeting:

17.1 **Tuesday 2 September 2025**

Meeting concluded at 14:40

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
5.2.2/24062025	24 June 2025	Contract Management Advisory Report - Follow Up	It was agreed that the committee schedule a follow up to the Contract Management Advisory Report in 6-9 months time, to ensure that the suggested actions in the report, particulary those involving Shared Services are being addressed. The matter of business will be added to the committee Forward Planner.	Trish Mills [Lisa Trounce]	2 March 2026	**Update 26052025**: Item of business included on the committee Forward Planner for the meeting of the committee in March 2026. Item status updated to 'complete' proposed for closure. Should the committee not be content with the follow up date, it can be adjusted. Proposed for closure.	Complete
5.2.3/24062025	24 June 2025	Seasonal Modelling and Forecasting Internal Audit Report	Hugh Bennett to discuss with Rachel Marsh and clarify position and resource requirements in relation to the agreed management actions within the Seasonal Modelling and Forecasting Internal Audit Report.	Hugh Bennett	2 September 2025	**Update 15/08/2025 from Hugh Bennett:** We have agreed to complete all the management acions from the audit, so any discussion around ressourcing (which are going on) are outside the Committee's remit. Proposed for closure.	Complete
6.1/24062025	24 June 2025	Audit Wales Update Report	Trish Mills stated that the checklist from Audit Wales had been added to the Board Induction Pack and would be circulated to the Non-Executive Directors.	Trish Mills	2 September 2025	**Update 27062025:** Audit Wales "Cost Savings Arrangment Checklist, A Checklist for NHS Board Members" was cirulated to all Non-Executive Directors via email.	Complete
6.2/24062025	24 June 2025	Urgent and Emergency Care Report	Fflur Jones to provide a realistic date for the completion of the National View Report on Collaboration Handover between organisations.	Fflur Jones	2 September 2025	**Update 21/08/2025 from Fflur Jones:** Audit Wales is currently in the process of scoping a national output for urgent and emergency care services, including meeting with various stakeholders. Audit Wales anticipates this output will be completed by the end of the 2025 calendar year.	Open
6.2/24062026	24 June 2025	Urgent and Emergency Care Report	Fflur Jones to double check the Urgent and Emergency Care Report's reference to the "no send" approach and confirm whether it accurately reflects the current status.	Fflur Jones	2 September 2025	**Update 21/08/2025 from Fflur Jones**: Following a discussion with Ceri Jackson, changes have been made to the report and sent to the the publishing team for alteration. Proposed for closure.	Complete
8.1/24062025	24 June 2025	Audit Tracker Update Q4 2024/25	It was agreed a detailed progress update on the Electronic Patient Clinical Records (ePCRs) actions will be scheduled for the Committee's September 2025 Forward Planner.	Trish Mills [Lisa Trounce]	2 September 2025	**27052025 Update from Lisa Trounce:** A meeting between Digital and Internal Audit took place last week (16th June) where the four outstanding audit actions (681, 683, 684 and 686) were discussed. It was agreed to extend the deadlines for these actions, which are on course for completion by the end of this year. A detailed update on the Q3 Audit Tracker Report will be will be provided to the Q4 ARAC meeting in March 2026.	Complete

AUDIT, RISK AND ASSURANCE COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

Trust Board Meeting Date	31 July 2025
Committee Meeting Date	24 June 2025
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. The **2024/25 Audited Financial Accounts** were presented and endorsed for approval by the board. Audit Wales were in attendance. The committee noted:

   - Total income was £325.2 million, with a corresponding expenditure, resulting in the break-even position. Key balance sheet items included a small reduction in debtors, a decrease in cash in bank, and a reduction in creditors. The capital expenditure limit was met with a spend of £20.5 million.

   - Audit Wales reviewed the accounts and provided their opinion. They noted the accounts were prepared in accordance with the required standards and provided a true and fair view of the Trust's financial position. A minor adjustment was noted regarding the treatment of benefits in kind for non-executive directors, which would be included in the final version of the accounts. The accounts were found to be robust and compliant with the relevant standards. The detailed work by the finance team was acknowledged and appreciated.

2. The **ISA 260** was presented by Audit Wales and the committee noted:

   - Audit Wales intends to issue an unqualified (clean) audit opinion on the accounts, subject to receiving the signed letter of representation.

   - The materiality for the audit was updated to just over £3.2 million, with a clearly trivial threshold of £163,000. Certain areas, such as the remuneration report and related party disclosures, had lower materiality levels due to their sensitivity.

   - No significant issues were identified during the audit. Some misstatements were corrected by management, but none impacted the final figures in the accounts. The corrected misstatements included adjustments to expenditure and income, reclassification within trade and other payables,

updates to the contingent liabilities note, and inclusion of omitted related party transactions.

- The standard letter of representation was requested to be signed by the Trust Board, with no additional wording required.

- Audit Wales emphasised the compliance with ethical standards during the audit and thanked the finance team for their cooperation and improvements from the previous year.

3. The **2024/25 Annual Report** was presented and endorsed for board approval. The committee noted:

   - The annual report consists of two parts: the performance report and the accountability report, developed in accordance with the Welsh Government Manual for Accounts.

   - The board had an opportunity to review the report in draft form previously and it has undergone scrutiny by Audit Wales and Welsh Government.

   - There are plans to start the report preparation earlier next year to streamline the process and reduce duplication. There is also an intention to coordinate with other end-of-year reports and consider creating an easy-read version for better accessibility.

   - All those involved in the development of this substantial report, showcasing the excellent work of the Trust in 2024/25 was recognised and commended.

4. A **non-compliance with Standing Orders** was reported and is brought to the board's attention. This related to the approval of settlement agreements for two employees in respect of Employment Tribunal cases. Due to an internal oversight, approval in each of these cases was not sought from the Chief Executive, Remuneration Committee or Welsh Government prior to entering into settlement negotiations. Retrospective approval was provided by the Remuneration Committee at its 3 June 2025 meeting. Adjustments have been made to internal controls to avoid future issues.

5. There was one **limited assurance internal audit** presented (Start of Shift Procedure – see paragraph 12).

ADVISE

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

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

7. The **No PO No Pay Policy** was received and will be presented to the Finance & Performance Committee for approval in line with the separate delegations set out in the Terms of Reference for financial policies and those for financial procedures. The national policy changes are intended to enhance compliance and streamline processes.

8. Members **reflected** that the high standard and quality of work and presentations reflect the professionalism and dedication of the staff involved. Members emphasised the importance of collaborative effort and the professionalism demonstrated by all participants, highlighting the effective teamwork across different roles and departments. They acknowledged the difficulty in achieving a balance between detail and conciseness in the reports and congratulated the team for striking this balance effectively, making the reports both comprehensive and accessible.

ASSURE

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

9. The Audit **Wales** update report was received. The 2025/26 Structured Assessment brief has been agreed and work is underway, with the deep dive for 2025/26 being a review of the arrangements to manage estates (due to be reported in March 2026). The 2024/25 deep dive review of investment in digital systems to support service resilience and transformation is due to be reported to ARAC in November.

10. The **WAST Urgent and Emergency Care – Arrangements for Managing Demand** report was presented by Audit Wales and will be before the board at its July meeting. The UEC work by Audit Wales examined different aspects of the urgent and emergency care system in three parts:

    - Part One: Flow out of hospital (not applicable to the Trust)
    - Part Two: accessing urgent and emergency care (this report)
    - Part Three: national arrangements and leadership structures

    The committee heard that the report highlighted the positive changes made by the Trust in managing urgent and emergency care demand, but members acknowledged the importance of collaboration with Health Boards to address systemic challenges and improve patient outcomes, expressing concern about the number of patients coming to harm due to handover delays and the need for urgent action. Members noted the need to consider a formal engagement plan to enhance communication and coordination within the wider system and noted the ongoing challenge of fragmented data systems, stressing the need for integrated data to have full visibility of patient pathways. The Committee noted the issue of Health Boards' legal responsibility to trigger the Duty of Candour for patients harmed by handover delays and that the triangulation of the data available could inform future audit activities.

11. The **2024/25 Head of Internal Audit Opinion** was received, and the committee commended the reasonable assurance rating, meaning that the Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Members were assured that sufficient audit work was undertaken during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards. The Head of Internal Audit Report is attached at **Annex 1**, and the board will note there were two substantial assurance audits, 13 reasonable with assurance, and four with limited assurance. Additionally, there was one advisory review. All service performance indicators for 2024/25 were green and members commended both management and Internal Audit for this achievement and for fostering strong, collaborative working relationships.

12. 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 (subject to a clarification on the seasonable forecasting and modelling audit) they were appropriate and timely. There is one review that was slightly delayed (111 Wales Website) which is in draft and will be presented to the next meeting:

- **Start of Shift Procedure – Limited Assurance**. The purpose was to assess compliance with the Shift Start and Finish Standard Operating Procedure (SOP), including the preparation of vehicles and to ensure that key equipment and medicines are available.

  The SOP sets out an agreed process for staff during the commencement and completion of operational shifts, which includes coverage to comply with the requirements of the Road Traffic Act 1998. These arrangements exist to ensure increased efficiencies at the commencement of each shift and clearly set out the requirements that should be followed by staff when they start their shift.

  The existing vehicle accident management task and finish group will be expanded to address the findings from this audit, given the correlation with the vehicle daily inspection forms. Members heard that vehicle checks are being done, but improvement was needed on the recording and reporting thereof. The task and finish group will work on an alternative system for recording and reporting. Time constraints and the immediate need to respond to calls were identified as barriers to recording checks. The task and finish group will explore solutions to improve efficiency.

  One objective was classified as substantial assurance (staff book onto the MDT immediately at the commencement of shift), two as reasonable, and three as limited. Two high and three medium priority management actions were raised. The Finance and Performance Committee has an oversight of the audit actions and will receive this report at its July meeting.

- **Follow Up Audit 2024/25 – Reasonable Assurance**. The purpose of this review was to provide assurance on the status of implemented recommendations on the audit tracker and review the systems and arrangements the Trust has in place to monitor progress with the implementation of actions.

  Whilst there was a need to seek further evidence of closure for some actions during the review, testing confirmed that 18 of the 18 recommendations tested as part of the review were appropriately classified as complete on the tracker. The Trust's closure rate in quarter 3 2024/25 of 67.9% is higher than the All-Wales average of 65.1%. There were no recommendations made as part of this review. There will be a new approach to this annual follow up audit in 2025/26, with the review taking place throughout the year.

- **Contract Management – Advisory Review (therefore no rating applied)**. The purpose of this review was to assess whether appropriate contract management arrangements were in place within the Trust. This was an all-Wales review and compared the appropriateness of contract management arrangements across eight health bodies, with common issues and challenges noted.

The Trust used this opportunity to assess its own contract management practices, and to develop a centralised contract register in readiness for the audit - the only health body to do so. While a centralised contract management system will not be pursued due to resource implications, the review identified strong pockets of good practice in higher-risk areas. For example, the Digital Directorate has a well-defined supplier contract SOP, and the Finance & Corporate Resources Directorate maintains a comprehensive capital contracts register. These areas demonstrated more advanced and structured contract management processes, reflecting their financial and reputational risk exposure.

The report also highlights the significant role of NWSSP Procurement Services in supporting all-Wales improvements. NWSSP is expected to lead on the development of consistent guidance, training, and education to strengthen contract management capabilities across NHS Wales bodies. In the meantime, a joint Siren Notice from the Finance and Corporate Governance Directors will reinforce key principles locally, including the need for designated contract managers, directorate-level registers, and clear reporting and escalation mechanisms.

ARAC noted these local actions and the continued collaboration with NWSSP on centralised improvements and will revisit this in nine months' time.

- **Seasonal Forecasting and Modelling – Reasonable Assurance**. The purpose was to assess the Trust's approach to forecasting and modelling, including a focus on winter resilience planning.

  A forecasting and modelling group, established during the COVID-19 pandemic, has become a permanent fixture, coordinating activities across the trust. Management acknowledged the findings and noted that while the structures and culture are strong, the processes need improvement. The desire to have a written framework and SOPs was discussed to ensure the quality and reliability of forecasting and modelling outputs, as well as the need to formalise the analysis of actual performance against forecasted models, which is currently done informally. Further clarity was sought by members as to whether further managerial capacity is required to address the recommendations fully and this will be revisited in September.

  Two objectives in the audit were rated reasonable assurance and one limited. Seven medium priority recommendations were raised. The Finance and Performance Committee has oversight of the audit actions and will receive this report at its July meeting.

- **Emergency Nurse Communications System Implementation (ECNS) – Reasonable Assurance**. The purpose was to provide assurance that benefits realised reflect those identified at the outset of the ECNS implementation.

  A significant backlog of audits was noted, with over 400 audits pending completion. An uplift of six auditors is expected in Q2 to address this backlog. There were discrepancies in monitoring tools and a lack of routine audits for clinicians, with 44% not receiving monthly audits as expected. No post-implementation review had been conducted, resulting in the absence of an evaluation of benefits realized and identification of lessons learned. There was no evidence of escalation of ECNS non-compliance, which could impact the trust's accreditation status. Reporting arrangements have been refreshed but need time to mature. Management acknowledged the findings and noted that the uplift in auditors and improved processes will address many of the key findings. Members were assured that the benefits of ECNS were realized

upon implementation and that the project plan pathway framework and templates will help ensure consistent benefits realization and monitoring across projects.

The need for formal evaluation and post-implementation reviews has been a common theme in previous audits, highlighting the importance of pausing to assess the effectiveness and benefits of projects. Oversight of these audit actions are with the Finance and Performance Committee, who are requested by ARAC to discuss further the role that committee has in monitoring the process of such evaluations in the Trust.

Three objectives were rated reasonable assurance, with two being limited. The Finance and Performance Committee has oversight of the audit actions and will receive this report at its July meeting.

- **Capital Systems – Reasonable Assurance**. The audit was focused on the selection, appointment and contractual arrangements applied at Capital and Estates projects. The audit provided substantial assurance for value for money, indicating effective use of resources in capital projects

  The audit reviewed the control framework, systems, and processes in place to manage discretionary EFAB and other capital estates funded schemes. While several processes support capital project progression, they are not fully documented, affecting consistency and standardization, and there was a lack of evidence for declarations of interest and non-collusion, particularly from shared services procurement office. One project lacked a signed contract, and contract amendments were not consistently annotated as accepted by both parties. The retention period within the NHS Wales Records Management code of practice is insufficient to cover the liability period for contracts executed as deeds.

  Similar reviews at other NHS Wales organizations revealed consistent issues with declarations of interest, non-collusion, and contract retention periods. Management acknowledged the findings and emphasised the need for improved processes with shared services procurement. Actions are in place to address the identified issues. The audit findings will be shared with shared services procurement to ensure compliance and mitigate risks. The policy is due for review in July, and the findings will be reiterated in the updated version.

  Two objectives were rated reasonable and one substantial (value for money). The Finance and Performance Committee has oversight of the audit actions and will receive this report at its July meeting.

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

    Key deliverables for 2025/26 include standardised templates and guidance for board and committee papers (Q1), meeting etiquette and a house style for minutes (Q2), an Accountability, Assurance and Governance Handbook (Q3), and the introduction of AI tools to support governance processes (Q4). The programme builds on strong foundations established through previous structured assessments

and committee effectiveness reviews, with further assurance updates scheduled for December 2025 and March 2026. Members are asked to note progress and the planned timeline for deliverables.

14. The **Losses and Special Payments** were reviewed for the period from 01 April – 31 May 2025 and noted as being -£1.248 million. The total net losses and special payments made during the period 01 April 2024 to 31 March 2025 amounted to £0.668. The committee acknowledged the importance of learning from these incidents to prevent future occurrences and emphasised the need for robust processes to manage and mitigate such losses.

15. The committee received the **Q4 2024/25 Audit Tracker update**, noting strong progress with 51% of internal audit actions closed 0 up from 27% in Q3, and 89% of remaining actions scheduled for closure by September 2025. Revised deadlines have decreased, and the ELT has removed the option for third extensions. 85% of external audit actions were also closed. One ARAC-related action remains open, due by Q2.

    Four actions remain open from the 2023/24 Electronic Patient Clinical Records (ePCR): Clinical Compliance internal audit and are on their third and final date. These actions, originally assigned to the Clinical Directorate, were transferred in March 2025 to the Digital Directorate. They relate to training validation, competency testing, module engagement, and data structure improvements. While interface enhancements have been made, clinician feedback highlighted usability issues, prompting the development of a new learning module. A review meeting between the Digital Directorate and Internal Audit was held just prior to this committee meeting with some deadline extensions and reframing of actions for the committee to review in September.

16. The Committee's **cycle of business monitoring report** was reviewed with no matters to escalate. Its priorities are on track.

17. In private session the Committee received **the Local Counter Fraud Service Annual Report** for 2024/25, the update report and work plan for 2025/26. The annual report and workplan for 2025/26 were approved by the committee. **The tender update and single tender awards** were also received, as was the audit tracker related to the Technical Resilience and Cyber Security Internal Audit recommendations.

RISK MANAGEMENT

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

19. The discussion primarily focused on the **repositioning of Risks 223 and 224** which separates the controls, assurances and gaps into internal and external themes and categories. There are plans to score the effectiveness of internal controls and assurances, which have been mapped against the three lines of assurance, and to introduce internal and external risk scores to demonstrate the impact of actions taken to mitigate the risk. Members were assured about the new approach, which supports the early identification of any gaps, and any escalations required, and which has already supported more

focused discussions on Risk 223 particularly in the areas of assurance. This approach could be implemented for other principal risks such as the Decarbonisation risk.

20. The **risk appetite statements** are being finalised in readiness for sign off by the Board and the development of a strategic BAF will be the focus for this year, including the creation of one or two strategic risks to be piloted in readiness for the Board Development Session in February 2026.

21. Interviews for the **Risk Manager** are scheduled for 11 July 2025 with the aim to support the enterprise risk management programme and to **explore digital solutions** for risk management as key pieces of work.

22. New tools have been developed to support continued effective risk management including dashboards describing trend data and mitigating actions impacting target scores.

23. Members agreed to support flexibility on the outline timings for the risk management work programme whilst new ways of working, processes and outputs are explored.

COMMITTEE AGENDA FOR MEETING IN JUNE		
Internal Audit: - Head of Internal Audit Opinion - Follow Up Audit - Contract management audit - Seasonal modelling and forecasting audit - Start of shift procedure audit - ENCS implementation audit - Capital systems audit	Audit Wales Report Urgent and Emergency Care Review	Risk management report
Audit tracker	Losses and special payments	NHS Wales No PO no pay policy
Integrated Governance Programme	Non-Compliance with SO	2024/25 Annual Accounts and Annual Report

COMMITTEE ATTENDANCE						
Name	**1 May 2025[1]**	**24 Jun 2025[2]**	**2 Sep 2025**	**2 Dec 2025**	**2 Mar 2026**	
Peter Curran						
Ceri Jackson						
Rhiannon Beaumont-Wood						
Chris Turley						
Audit Wales	Fflur Jones	Fflur Jones				
Julie Boalch						
Judith Bryce	Jon Sweet					
Christian Fox						
Carl Kneeshaw						

[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

COMMITTEE ATTENDANCE						
Name	**1 May 2025[1]**	**24 Jun 2025[2]**	**2 Sep 2025**	**2 Dec 2025**	**2 Mar 2026**	
Osian Lloyd						
Trish Mills						
Liam Williams		Wendy Herbert				
Carl Window						
Damon Turner						

	Attended
	Deputy attended
	Apologies received
	No longer member

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

AGENDA ITEM No	**5**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

STANDING FINANCIAL INSTRUCTIONS CHAPTER 11 PROCUREMENT ACT 2023

MEETING	Audit, Risk & Assurance Committee
DATE	2 September 2025
EXECUTIVE	Chris Turley, Executive Director of Finance and Corporate Resources
AUTHOR	Jessica Price, Head of Financial Accounting
CONTACT	Jessica.Price3@wales.nhs.uk

EXECUTIVE SUMMARY

1. From the 24th February 2025, the Procurement Act 2023 and associated subordinate instruments (together "the 2023 Act") and the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and associated subordinate instruments (together "the PSR Wales Regulations") are the key pieces of legislation which governs public sector procurement in the UK.

2. Following the introduction of the 2023 Act, chapter 11 of the Trust's Standing Financial Instructions (SFIs) have been amended to reflect the changes in accordance with that issued by the Welsh Government.

RECOMMENDATION

3. The Audit, Risk & Assurance Committee is requested to endorse the amendments to chapter 11 of the SFIs and recommend their approval to the Trust Board.

KEY ISSUES/IMPLICATIONS

4. The legislation governing public procurement is now broken down between "In-Scope Health Services" in which the PSR Wales Regulations apply and "Goods and Non-Health Services" which falls within the scope of the 2023 Act.

5. The PSR Wales Regulations governs the procurement of In-Scope Health Services. One of the key objectives of the legislation is to ensure there is more flexibility when selecting providers for health services.

6. The 2023 Act governs the procurement of Goods and Non-Health Services. A key objective of the legislation is to establish a flexible, accessible and equitable framework for public procurement in Wales.

7. The changes to the 2023 Act have resulted in new processes being implemented both internally and externally via NHS Wales Shared Services Procurement.

REPORT APPROVAL ROUTE
Audit Committee 2nd September 2025 – endorsement and recommended approval to the Trust Board. Trust Board – 25th September 2025 – for approval

REPORT APPENDICES
Annex 1 – Welsh Health Circular WHC/2025/012 Annex 2 – Updated Chapter 11 of the SFI as issued by Welsh Government Annex 3 - Tracked changes to Chapter 11 of the SFIs

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST
AUDIT, RISK AND ASSURANCE COMMITTEE
STANDING FINANCIAL INSTRUCTIONS CHAPTER 11
PROCUREMENT ACT 2023

SITUATION

1. The Trust's Standing Financial Instructions (SFIs) are based upon the model determined by Welsh Government. The SFIs require updating due to the introduction of the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and the Procurement Act 2023.

BACKGROUND

2. The Welsh Government has made amendments to the model document to comply with the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and the Procurement Act 2023 as per the Welsh Health Circular WHC/2025/012 (Annex 1). These amendments are to be reflected in Chapter 11 of the Trust's Standing Financial Instructions.

ASSESSMENT

3. The updated Chapter 11 as issued by Welsh Government (Annex 2) along with a tracked changes version of all amendments to Chapter 11 of the SFIs (Annex 3) have been included within the ibabs Reading Room.

Legislation Governing Public Procurement

4. The main changes in relation to Legislation Governing Public Procurement are that we will now see a split between In-Scope Health Services and Goods and Non-Health Services.

In-Scope Health Services

a. The Health Services (Provider Selection Regime) (Wales) Regulations 2025 ("the PSR Wales Regulations") only apply to certain health services ("In-Scope Health Services").
b. Where specific instructions relates only to procurements undertaken under the PSR Wales Regulations, the words 'In-Scope Health Services Only' will appear at the start of the instructions paragraph.

c. One of the key objectives of this legislation is to ensure there is more flexibility when selecting providers for health services, with competitive tendering being one tool for the Trust to use when it is of benefit; alongside other routes that may be more proportionate, and which better enable the developments of stable partnerships and the delivery of collaborative care (para 11.3.4 of Annex 2).

Goods and Non-Health Services

d. Goods and services which are not In-Scope Health Services ("Goods and Non-Health Services") fall within the scope of the Procurement Act 2023 ("the 2023 Act").
e. Where specific instructions relates only to procurements undertaken under the 2023 Act, the words 'Goods and Non-Health Services Only' will appear at the start of the instructions paragraph.
f. A key objective of the legislation is to establish a flexible, accessible and equitable framework for public procurement in Wales that maximises social, economic, environmental and cultural outcomes for communities across Wales (para 11.3.3 of Annex 2).

Procurement Principles and Objectives

5. The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the Trust.

6. Goods and Non-Health Services Only – the legal and governing principles guiding 'covered procurement' under the 2023 Act, and incorporated into these SFIs include but are not limited to the following:
   a. Having regard to the objectives of delivering value for money; maximising public benefit; sharing information for the purpose of allowing suppliers and others to understand the authority's procurement policies and decisions; acting, and being seen to act, with integrity; and removing or reducing the barriers faced by SMEs.
   b. Ensuring equal treatment by treating suppliers the same, unless differences between the suppliers justify different treatment (and where different treatment of suppliers is justified, to take all reasonable steps to make sure the different treatment does not put a supplier at an unfair advantage or disadvantage).

7. In Scope Health Services Only - the legal and governing principles guiding procurement of In-Scope Health Services under the PSR Wales Regulations, and incorporated into these SFIs include but is not limited to the Trust doing the following:

a. Making decisions in the best interests of people who use the service by acting with a view to (1) securing the needs of the people who use the services; (2) improving the quality of the services; (3) improving efficiency in the provision of the services;
b. Acting transparently, fairly, and proportionately;
c. Having regard to the Welsh Government's Health service procurement: statutory guidance; and
d. Having regard to the Wales Procurement Policy Statement published under section 14 of the 2023 Act.

(Para 11.4 of Annex 2)

Procurement Procedures

8. To help towards ensuring that the Trust is compliant with the legislation governing public sector procurement in the UK, and Welsh Ministers' guidance and policy, the Trust shall, through Procurement Services, ensure that it shall have procedures that set out:
    a. requirements for, and exceptions to, formal competitive tendering ('Goods and Non-Health Services Only');
    b. tendering processes including post tender discussions;
    c. requirements and exceptions to obtaining quotations ('Goods and Non-Health Services Only');
    d. evaluation and scoring methodologies; and e) approval of firms for providing goods and services.

    (Para 11.5 of Annex 2).

9. The NHS Wales Shared Services Procurement team have now introduced new processes to ensure the Trusts procurement processes align with the 2023 Act. The Trust is working with procurement to embed the internal processes with further training, where required, being developed.

RECOMMENDATION

10. The Audit, Risk and Assurance Committee is requested to **endorse** the amendments to the Standing Financial Instructions in accordance with the Welsh Government update and recommend their approval to the Trust Board.

Internal Audit Progress Report

Audit, Risk and Assurance Committee

September 2025

Welsh Ambulance Services University NHS Trust

NWSSP Audit and Assurance Services

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

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

Contents

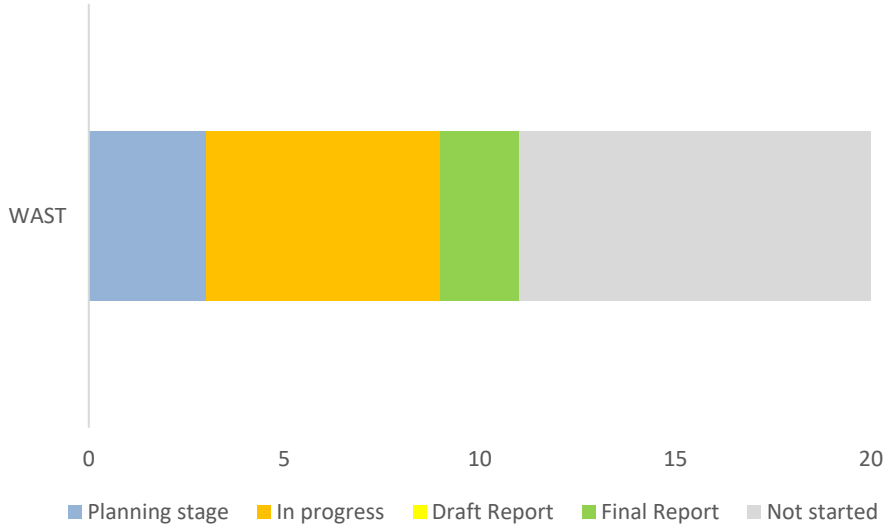
1. Introduction

The purpose of this report is to:

- highlight progress of the 2025/26 Internal Audit Plan to the Audit, Risk and Assurance Committee; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2025/26 Internal Audit Plan

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



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

3. Proposed changes to approved plan

The scope of the Capital Provision audit in the 2025/26 Internal Audit Plan—initially marked as "to be confirmed"—will focus on the Ambulance Replacement Programme. The review will assess the Trust's arrangements for managing and controlling the refresh of its fleet, including emergency, non-emergency, and specialist support vehicles. This audit is proposed to take place in Quarter 3 or Quarter 4, subject to Welsh Government funding approvals and timing.

4. Engagement

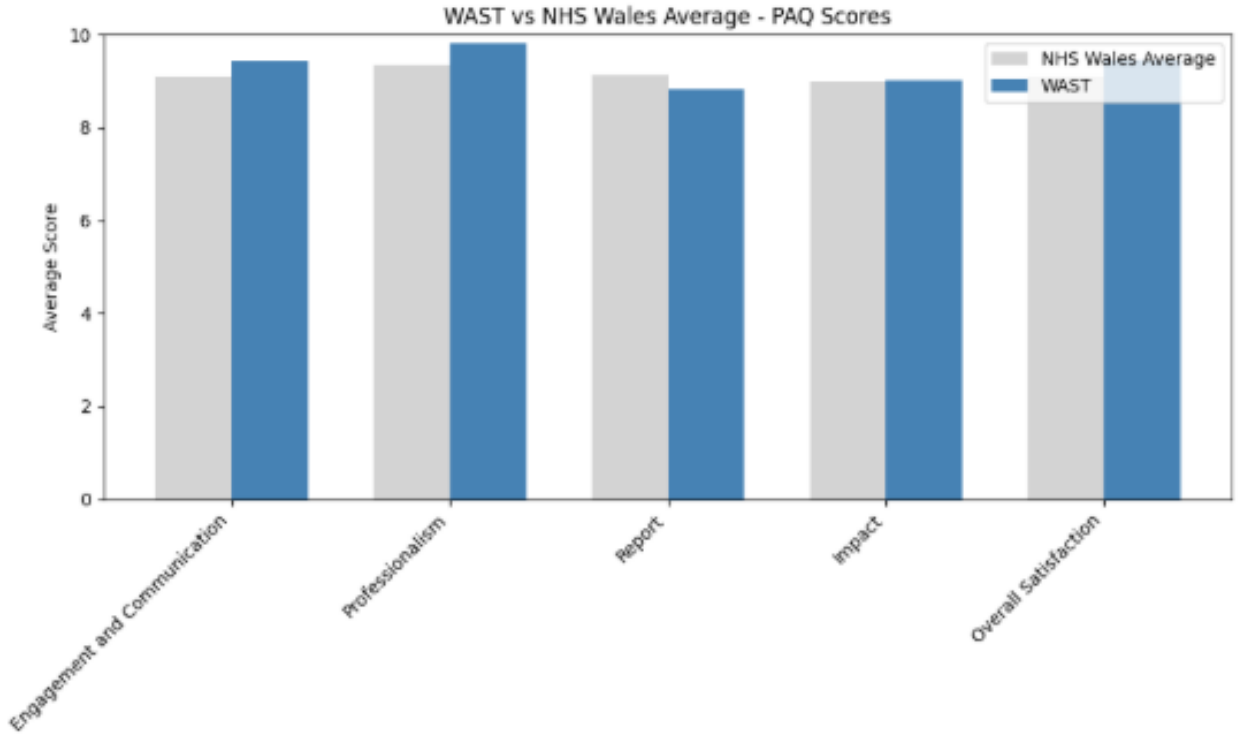
The following meetings have been held/attended during the reporting period:

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

- liaison with external regulators.

5. Post Audit Questionnaire (PAQ) Feedback – 2024/25

The use of Microsoft Forms has improved national engagement, with the Trust achieving a 55% response rate to PAQs—closely aligned with the national average of 57%. Satisfaction scores were generally positive and broadly in line with national averages.



Feedback highlighted recurring themes of professionalism and supportive audit delivery.

6. Key Performance Indicators

Correct on 30 August 2025

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2025/26	●	March	By 30 June
Audits reported over planned	●	2	2
Work in progress		6	
Report turnaround: time from fieldwork completion to draft reporting [10 days]	●	2 out of 2	80%
Report turnaround: time taken for management response to draft report [15 days]	●	2 out of 2	80%
Report turnaround: time from management response to issue of final report [10 days]	●	2 out of 2	80%

Key:

- ● v>20%
- ● 10%<v<20%
- ● v<10%

7. Recommendation

- The Audit, Risk and Assurance Committee is invited to note the above; and
- Approve the proposed changes at section 3.

Appendix A: Progress against 2025/26 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Risk Management and Assurance	Not started			May / June 2026
Welsh Language Standards	Not started			March / April 2026
Follow Up	In progress	A sample of closed recommendations will be validated on a rolling basis, with updates provided at each Audit, Risk and Assurance Committee meeting and a summary report prepared at year-end to capture the overall status.		May / June 2026
Budget Setting	Not started			March / April 2026
Clinical Equipment	In progress			December 2025
Clinical Model Transformation Programme Management	Not started			March / April 2026
Integrated Medium Term Plan (IMTP) Development Process	In progress			December 2025
Cymru High Acuity Response Unit (CHARU)	Planning			December 2025
Remote Clinical Support	Not started			March / April 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	Not started			March / April 2026
High Risk Record Policy	Not started			May / June 2026
Data management practices / Devolved data	In progress			December 2025

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Emerging technology adoption	Planning			March / April 2026
Business Continuity	Planning			May / June 2026
Organisational Change Policy	Final report	Reasonable	Processes for managing organisational change are developing but require clearer guidance, improved planning, consistent application, better monitoring, and structured learning to support effective delivery and continuous improvement across the Trust.	September 2025
Mandatory In-Service Training (MIST)	In progress			December 2025
Job Evaluation	Not started			May / June 2026
Ambulance Replacement Programme	Not started			May / June 2026
Fire Safety	In progress			December 2025

[1] May be subject to change

Manchester Arena Inquiry

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust

Substantial Assurance

Contents

Review Reference	WAST-2526-10
Fieldwork	June – July 2025
Executive Sign Off	7 August 2025
Audit Committee	2 September 2025
Executive Lead	Lee Brooks, Executive Director of Operations
Audit Team	Osian Lloyd, Head of Internal Audit
	Felicity Quance, Deputy Head of Internal Audit

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

Executive Summary

Purpose

To review the progress made by the Welsh Ambulance Services University NHS Trust (the Trust) to address and learn from the recommendations raised from the Manchester Arena Inquiry; and to assess the governance and reporting arrangements established, including a validation exercise to support the closure of actions.

Overview

Following the events of the Manchester Arena bombings of May 2017, an inquiry was launched into the emergency response to the incident and examined the planning and preparation by the responders and their adequacy. The 'Manchester Arena Inquiry Volume 2: Emergency Response', report was issued in November 2022 and identified weaknesses and failings in the emergency response for which 149 recommendations have been determined. Our review focussed on the 68 findings and recommendations that more widely impacted the Trust, and the subsequent procedural changes required should a similar event occur in the future.

The Trust has taken a proactive approach to addressing the Manchester Arena Inquiry recommendations, with **substantial assurance** provided overall. An action plan has been developed and implemented, supported by robust internal reporting and governance arrangements. Evidence of meaningful change includes the introduction of new equipment, enhanced training programmes, and revised emergency response procedures. The Trust's engagement with national coordination efforts and its transparent approach to risk management further reinforce the positive direction of travel. One matter has been raised for management attention regarding the training delivered through the Mandatory In-Service Training (MIST) days. While the content was appropriately included, full delivery had not been achieved due to non-attendance by a number of staff; however, we note a satisfactory level of attendance was deemed achieved to allow the same to 'go live'.

Full details are included within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	There is an approved action plan in place which reflects the recommendations raised and the lessons learned.	-	**Substantial**
2	Appropriate governance mechanisms are in place to monitor and manage progress against planned actions, the robustness of the evidence to support the action, and their continued sustainability	1	**Reasonable**
3	Periodic reports on the progress against implementation of the action plan are produced and submitted to appropriate management and Trust committees for oversight and escalation.	-	**Substantial**

Management Actions

0 High Priority

1 Medium Priority

Themes

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Manchester Arena Inquiry - At a Glance

As part of this audit, ten recommendations were selected for sampling. Evidence was reviewed to assess the robustness and sustainability of actions taken in response. The findings are summarised below:

Reference	Recommendation	Summary of Evidence Reviewed
1	The Greater Manchester Resilience Forum should oversee a biannual tri-service review of Major Incident plans to ensure mutual understanding and embed joint working.	Although not directly applicable to the Trust, an All-Wales emergency services group – the *Tri-Service Incident Plan Review Group (TriSIP RG)* – has been established.
27	North West Ambulance Service should improve its record-making practices during and after Major Incidents.	The Trust has updated its *Incident Response Plan (IRP)* to align record-keeping processes with best practice.
45	National bodies should review and update the Joint Doctrine and Joint Operating Principles for Marauding Terrorist Attacks.	Staff bulletins were issued via *Siren* outlining updated guidance. Section 7 of the IRP was also revised accordingly.
56	Police services should establish a hotline for emergency service commanders during Operation Plato.	While not directed at ambulance services, the Trust has implemented a *Major Incident Hotline* to support effective call handling.
105	Ambulance trusts should assess their capacity to respond to mass casualty incidents, including specialist personnel availability.	The Trust provided three key reports and supporting documentation, all approved by the Trust Board, identifying current gaps and outlining capability assessments.
111	Hazardous Area Response Team (HART) personnel should receive enhanced care training to ensure advanced interventions are available on every deployment.	The Trust developed and delivered an *Enhanced Skills Training Course* for HART paramedics, aligning with Cymru High Acuity Response Unit (CHARU) standards.
113	Emergency responders should be trained in the Ten Second Triage tool.	The Trust embedded *Ten Second Triage (TST)* and *Major Incident Triage Tool (MITT)* into practice, with training delivered via the annual *MIST Day* programme.
115	National bodies should review evacuation models to assess best practice globally.	While part of broader national research, the Trust has proactively introduced TST & MITT and updated the IRP.
123	Guidance should be issued on equipment for bridging interventions in warm zones.	Although awaiting national guidance, the Trust has implemented some bridging interventions in the interim.
148	A review should ensure appropriate stretchers are available in sufficient numbers and locations.	A bulletin was issued on the use of *PAX carry sheets* during major incidents, with training incorporated into the 2024/25 *MIST Day* programme.

Findings & Agreed Action Plan

Objective 1: There is an approved action plan in place which reflects the recommendations raised and the lessons learned.	**Substantial**

In August 2023, following review of the 149 recommendations outlined in the Manchester Arena Inquiry (MAI) report, an initial list was presented to the Senior Leadership Team (SLT). This detailed 71 recommendations that the Trust would take forward, and 78 recommendations that were deemed not applicable to the Trust as they related to external organisations such as the Home Office and Police Authorities. The SLT approved this categorisation at the same meeting.

The report also included the RAG (Red, Amber, Green) rating for each of the 71 applicable recommendations. Of these, nine were proposed for immediate closure, as existing arrangements within the Trust were deemed to already meet the expectation. A subsequent report, approved by SLT in December 2023, revised the number of recommendations the Trust would respond to from 71 to 68.

While a formal action plan was not produced in the traditional format, i.e. with defined timescales, responsible owners, and detailed actions, a spreadsheet was developed. This document included the text each recommendation, high-level progress updates, links to supporting evidence, and the corresponding RAG status. Further consideration of the action plan's management is considered under objective 2.

The Trust's response to the MAI recommendations demonstrates lessons learned, with evidence provided for 48 recommendations at the conclusion of audit fieldwork. These responses include a range of measures such as the introduction of new equipment, enhanced training for specialist roles, and revised procedures and arrangements for responding to similar incidents in the future.

Where the Trust has been unable to implement certain recommendations, these have been captured in the Corporate Risk Register (*#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; risk score 20*). This risk outlines the current gaps in controls, the capability shortfalls, and the assurance targets required to fully address the outstanding recommendations.

Objective 2: Appropriate governance mechanisms are in place to monitor and manage progress against planned actions, the robustness of the evidence to support the action, and their continued sustainability.	**Reasonable**

Under the leadership of the Executive Director of Operations, an Operations Support Manager was appointed to oversee the implementation of the MAI recommendations, supported by a Support Officer within the Emergency Preparedness, Resilience and Response (EPRR) team.

Internal monitoring arrangements were established within the EPRR team, including fortnightly highlight reports submitted to the Head of Service for EPPR, summarising progress against each recommendation. In addition, monthly highlight reports were prepared for the Assistant Director of Operations, and bi-monthly reports for the Executive Director of Operations. It is noted, however, that while regular meetings were held, the absence of formal outputs or minutes limits the ability to evidence oversight and decision-making. Further detail on internal reporting arrangements is provided under Objective 3 below.

At the commencement of audit fieldwork, 48 of the 68 recommendations had been marked as complete. To assess the appropriateness of the Trust's response, a sample of 10 closed recommendations was selected for detailed review (see page 2). Supporting evidence was provided for each, including relevant SBARs (Situation, Background, Assessment, and Recommendation reports) presented to the SLT for closure, along with the meeting minutes confirming their approval.

Three of the sampled recommendations (numbers 111, 115 and 148) related to the introduction of new equipment and the associated training requirements. It was noted that this training was scheduled to be delivered through the 2023/24 and 2024/25 Mandatory In-Service Training (MIST) days. While the training content was incorporated into the relevant sessions, a separate audit (as part of the 2025/26 Internal Audit plan - Mandatory In-Service Training) identified that approximately 300 staff members in 2023/24 and 230 in 2024/25 did not attend and therefore did not receive the required training. (**See Key Finding 1**). We note, however, that approval for 'go live' of the equipment, with effect from 1 April 2024, was provided at the Senior Operations Team meeting (March 2024) noting that an acceptable MIST compliance rate was deemed to have been achieved for EMS Response (81.4%) and arrangements for training made for the remaining staff.

At the conclusion of audit fieldwork, two of the 68 recommendations remained open, although we were advised that both are pending closure. The remaining 18 recommendations were identified as requiring further financial investment. These have been referred to the NHS Wales Joint Commissioning Committee (JCC) for consideration of funding to address the care gap and the Trust's current inability to fully implement the recommendations (refer to objective 3 for further details on the reporting arrangements in place). These 18 recommendations are also reflected in Corporate Risk #641 (see objective 1).

This transition brings the remaining unaddressed recommendations into a business-as-usual process, enabling the long-term management of associated risks, actions and the Trust's broader response.

Key Findings		Risk & Impact	Agreed Management Action
1	**Impact of MIST Day non-attendance** In relation to four recommendations from the MAI (including one not selected for sample testing), the Trust has developed and adopted specific measures to enhance its ability to respond effectively to a major incident. These measures were supported by face-to-face training sessions delivered through the Trust's MIST days. However, analysis of attendance data highlights potential gaps in training coverage: • Ten Second Triage Tool (TST)/Major Incident Triage Tool (MITT) – These tools represent improved triage arrangements adopted by multi-agency emergency services across Wales. Training was delivered via a 17-slide presentation during the 2023/24 MIST days. However, attendance records indicate that 194 Emergency Medical Services (EMS) staff and 112 Ambulance Care Services (ACS) staff did not attend (approximately 10% of the workforce). There is no evidence to confirm whether these staff received the training through alternative means. • Pax Carry Sheet –This lightweight, high-quality, and versatile rescue aid was procured for every emergency vehicle across the Trust. Training was delivered via a single slide within the broader 'Safer Handling' session during the 2024/25 MIST days. Attendance data shows that 168 EMS staff and 65 ACS staff did not attend (approximately 11% of the workforce), and again, there is no evidence of alternative training provision for these staff. Whilst we acknowledge that an acceptable MIST compliance was deemed to have been reached, to facilitate 'go live' of the equipment from 1 April 2024 (81.45% as at 12 March 2024), review of the Trust's current training arrangements did not identify any plans to provide further coverage of these specific training needs. While the financial submission to the NHS Wales Joint Commissioning Committee (JCC) highlights training gaps, these relate specifically to additional training for major incident Commanders, rather than the frontline training requirements associated with the MAI report recommendations.	Not all staff have received the required training to use new tools effectively, limiting the Trust's ability to deliver a fully effective major incident response.	**Agreed Action:** Following the feedback received, a multi-disciplinary team has identified solutions to address the issue. It was noted that the audit numbers (194 EMS and 112 ACAs) may have decreased as employees returned from absences like long-term illness or maternity leave. The ESR team is working to identify those who still need training. The Learning & Development team will then engage with these individuals to ensure compliance with the new triage tools and PAX carry sheets. An eLearning package by L&D has been recommended as the most efficient method for delivering remedial training. This package will be hosted on the Trust's LMS365 platform and made available to all staff, supporting ongoing CPD activities and new starters. We are consulting with neighbouring ambulance services for similar training materials to expedite this process. If unavailable, the Trust can develop its own materials using existing resources. Development of a new eLearning package may take until the end of Q3, but utilising existing packages could significantly reduce this timeline. The EMS Management Group (EMG) will monitor compliance and progress. Once available, the eLearning package will be a monthly agenda item for EMG to track progress and address any issues. Progress reports will be provided through standard assurance routes. We aim for completion by the end of the 2025/26 financial year, assuming all staff can undertake training. EMG will oversee this action until all necessary staff have completed the required training with approval for sign off to be sought from SOT.
			Expected Evidence of Implementation: Triple A reports from EMG into SOT on the monthly reporting of compliance.
		Medium Priority	**Officer:** Judith Bryce, Assistant Director of Operations **Target Implementation Date:** 28 February 2026
	Theme: Training & Development	Control Design	

Objective 3: Periodic reports on the progress against implementation of the action plan are produced and submitted to appropriate management and Trust committees for oversight and escalation.	**Substantial**

Internal Reporting

As outlined under objective 2, progress on implementing the MAI recommendations have been reported at various levels within the Trust:

- Operational Oversight: Fortnightly, monthly and bi-monthly updates were provided to management and executive leadership, including the Senior Leadership Team (SLT), following the approval of the initial list of recommendations.
- SLT Reporting: Periodic reporting to SLT (a total of 13 papers presented between August 2023 and March 2025) included lists of recommendations proposed for closure, narrative justifications for the Trust's response, supporting documentation, and evidence of scrutiny through meeting minutes. Where further work was required, recommendations were re-presented for approval.
- Committee Oversight: Due to the sensitive nature of the MAI response, detailed progress reporting was undertaken at closed sessions of the Finance and Performance (F&P) Committee (July 2024) and Trust Board (July 2025 and January 2025). Evidence of these sessions was provided, although the documentation was limited in scope.
- Open Committee Updates: High level updates were included in the Operations Directorate's quarterly reports, presented at open sessions of both Quality, Patient Experience and Safety (QuEST) and F&P Committees (noting that the same paper is presented at both). Some minutes included evidence of scrutiny and discussion from Committee Members.

Recognising the need to strengthen governance arrangements, the Trust has recently developed an integrated governance map, approved by the Audit, Risk and Assurance Committee in March 2025. This map outlines key principles to support effective oversight and accountability across meetings, clarify roles and responsibilities, and improve meeting administration. In relation to the Senior Operations Team (SOT) and SLT which sit under the Operations Directorate, the Integrated Governance Programme paper confirms that governance standards for directorates have not yet been developed.

External Reporting

- MAI report Monitoring: Of the 149 recommendations in the MAI report, 75 were subject to external monitoring and required feedback to the Chief Investigator. However, this applied only to named emergency services. As the Trust (WAST) was not named, no formal request for an update has been received to date.
- JCC: As part of the arrangements to secure additional funding to address the care gap identified in relation to the 18 recommendations (as noted under objectives 1 & 2), financial submissions have been made to the JCC setting out the funding required. Further, an update of the work being undertaken by the Trust and the Health Boards to respond to the findings of the inquiry was presented at the July meeting (15 July 2025), with specific reference to the three recommendations that the Joint Committee need to be aware of (namely recommendations 105, 106 and 107)
- Association of Ambulance Chief Executives (AACE) Coordination: The Association of Ambulance Chief Executives (AACE) identified 77 recommendations from the original MAI report as relevant to UK ambulance services. To coordinate a national response, AACE established the Manchester Arena Report Operations Group (MAROG). The Trust was required to document its progress against these recommendations in a quarterly submission to MAROG. This process enabled peer review across UK ambulance services to assess the consistency and appropriateness of response. Discussion with Trust officers confirmed that that nine of the MAROG recommendations were excluded from the Trust's response as they related to other emergency service organisations. These exclusions were clearly documented in the MAROG submissions.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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.

Organisational Change

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust

Reasonable Assurance

Contents

Review Reference	WAS-2526-16
Fieldwork	June - July 2025
Executive Sign Off	8 August 2025
Audit Committee	2 September 2025
Executive Lead	Carl Kneeshaw, Director of People; Angela Lewis, Director of Culture & Change
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

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

Executive Summary

Purpose

To evaluate the processes in place within the Trust to effectively manage organisational change.

Overview

The Welsh Ambulance Services University NHS Trust's (the Trust) Integrated Medium-Term Plan (IMTP) 2025-28 outlines a commitment to building change capacity and capability across the organisation by embedding a change management framework, which is also reflected within the People and Culture Plan (2023-26). It is in the early stages of implementation, but the aim is to embed effective change management principles through a people-centred and cultural approach.

Our audit focused on the Organisational Change Policy (OCP), a formal process governed by national policy and employment legislation for changes impacting staff roles or working conditions. Given the pace and scale of transformational activity within the Trust, enhancements are needed within this process to ensure sufficient resource capacity is in place to support effective delivery. While it has already been recognised that greater integration is required between project and programme management and wider change initiatives, earlier engagement and planning will be essential to enable better co-ordination of staff resources, support delivery, and drive continuous improvement. Additionally, consideration may need to be given to the outcomes of the ongoing Service review - designed to optimise how teams work together efficiently and effectively - as it has not yet been determined whether OCPs will be required.

We have concluded that reasonable assurance can be provided in relation to the Trust's change management arrangements. However, the following matters require management attention:

- **Guidance and Documentation:** There are currently no documented procedures to support managers in implementing the OCP. In addition, the templates provided for the OCP process need to be strengthened to ensure key factors such as resource capacity and approval requirements are considered from the outset.
- **Process Recording and Monitoring:** To improve the effectiveness of change management, a robust mechanism is needed to record key elements of the OCP process. This will enable earlier engagement, support effective prioritisation and resource planning, and facilitate ongoing monitoring.
- **Consistency in OCP Application:** Although testing results were generally positive, the application of the OCP process was found to be inconsistent. Greater alignment with the project management framework would support improved consistency, but the process itself must be strengthened to ensure that individuals with the appropriate skills and experience are involved.
- **Governance and Engagement:** The governance structure provides appropriate oversight of change management arrangements and ensures escalation of key issues where necessary. However, further clarification is needed to ensure consistent classification and reporting to the People and Culture Committee of OCPs as formal projects.
- **Lessons Learned and Benefits Realisation:** There is currently no formal mechanism to capture and share lessons learned or to track benefits realisation of change initiatives. Establishing such a process would support continuous improvement and help embed learning across the organisation.

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

Scope & Assurance Summary

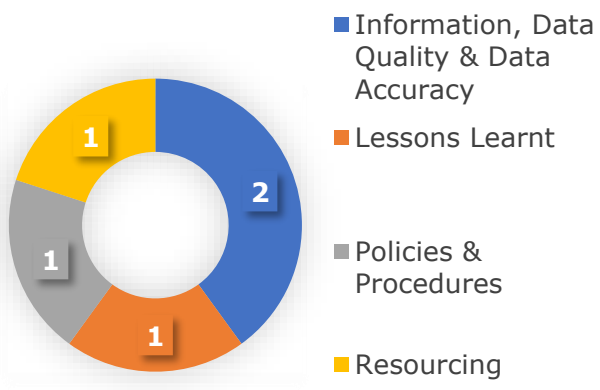
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Trust has appropriate policies in place which set out the arrangements to manage and implement organisational change.	1	**Reasonable**
2	Organisational change requests within the Trust have been recorded, evaluated, approved and been effectively delivered.	1, 2, 3, 4	**Reasonable**
3	The Trust has a process for identifying key stakeholders when undertaking organisational change and ensure they are engaged, consulted and have been provided with the necessary support.	1	**Reasonable**
4	The Trust monitors and receives sufficient reporting and assurance of organisational change, and continuous improvement and learning is promoted.	2, 3, 5	**Reasonable**

Management Actions

1 High Priority

4 Medium Priority

Themes



Risk Types

Public Perception & Reputational Risk

Quality or Safety Issues

Organisational Change - At a Glance

The audit reviewed four OCP areas, focussing initially on the documentation of key elements at the outset of each process:

OCP Area	Project	Rationale	Risks	Benefits	Milestones	Approval	EQIA	QIA	Job Description
Advanced Paramedic Practitioner (APP) – restructuring roles to align with the strategic direction of the Trust and the national position.	Yes, included an options appraisal and issues log.	Yes, within the consultation document.	Yes, within a project risk log. Not detailed within the consultation document.	Yes, within a benefits register. Not detailed within the consultation document.	Yes, within the project matrix and consultation document.	Approved by Senior Leadership Team (SLT). Executive Leadership Team (ELT) approval indicated but not evidenced.	Equality Impact Assessments (EQIA) completed but no confirmation of review by the Inclusion and Engagement team.	No Quality Impact Assessment (QIA) completed.	Job descriptions reviewed during OCP process but impacted timelines.
Volunteers Service – restructuring of service to reduce inefficiencies and provide clearer lines of responsibility and accountability.	No	Yes, within the consultation document.	No	Yes, within the consultation document.	Yes, within the consultation document.	Approved by SLT. ELT approval indicated but not evidenced.	Completed but no confirmation of review by the Inclusion and Engagement team.	Completed.	The OCP has been closed but some revised job descriptions pending agreement.
Bryn Tirion Relocation – existing building was not fit for purpose so needed an alternative (Ty Elwy) that could meet current and future requirements.	Yes, included an options appraisal.	Yes, within the Project Initiation Document (PID), Transition Plan, and consultation document.	Yes, within a risk register.	Yes, within the PID and consultation document.	Yes, within a Gantt Chart and the consultation document.	Approved by Strategic Transformation Board (STB); included in the IMTP by Project Board.	Completed and confirmed reviewed by the Inclusion and Engagement team.	Completed.	Not applicable.
Putting Things Right (PTR) – £270k investment to build capacity and succession planning within the team as well as compliance with key legislation.	No	Yes	Yes, within the consultation document.	Yes, within the business case. Not detailed within the consultation document.	Yes, within the OCP Roles Plan and consultation document.	ELT approval not explicit. ELT minutes (23/08/23) agreed to the recruitment of additional staff.	No evidence provided.	Indicated as completed, but no evidence provided.	Reviewed prior to OCP initiation.

The phase of the audit assessed how each OCP area managed stakeholder engagement, oversight and learning processes:

OCP Area	Consultation	Reporting	Benefits Realised	Lessons Learnt
Advanced Paramedic Practitioner (APP)	Consultation process documented, including formal notice, trade union involvement, and a feedback summary.	Reported to: • Advanced Clinical Practice Delivery Group (ACPDG). • Finance & Performance Committee (FPC) (20 May 2025). • People & Culture Committee (PCC) (15 May 2025 and 18 February 2025). • Quality, Patient Experience and Safety Committee (QuEST) (9 May 2025). • Trust Board (27 March 2025) and (30 January 2025).	Benefits register in place but not updated due to early stage of implementation (February 2025).	Lessons learnt log exists; highlights delays due to job description timing. Not widely disseminated.
Volunteers Service	Similar to APP, but the standard template was not used despite feedback being documented.	Reported to: • SLT (10 June 2025) with specific reference to the OCP in the context of non-recurrent funding for posts. • PCC (15 May 2025 and 14 November 2024). • Trust Board (27 March 2025).	No evidence of benefits realisation.	No lessons learnt recorded.
Bryn Tirion Relocation	Followed the APP consultation model; however, formal feedback document was produced. A Frequently Asked Questions document was used.	Updates provided to: • Project Board. • FPC (20 May 2025). • PCC (15 May 2025 and 30 August 2024). • QuEST (9 May 2025).	No benefits realisation recorded.	PID references lessons learnt. Project Board minutes (28 May 2025) note intent to circulate a lessons learnt document, but none recorded.
Putting Things Right (PTR)	Aligned with the APP approach, with additional elements: a launch presentation during an away day, an agreement to reduce the consultation period to three weeks, and updates to the consultation document based on feedback.	Reported via: • Trust Board risk register (risk 224 significant handover of care delays). • PCC (30 August 2024, 9 May 2024, 20 February 2024 and 16 November 2023). • QuEST (8 February 2024 and 31 October 2023). • Trust Board (25 January 2024).	No evidence of benefits realisation.	No lessons learnt recorded.

Findings & Agreed Action Plan

Objective 1: Appropriate policies for managing and implementing organisational change.	**Reasonable**

Overview / Summary of Observations

The Trust is in the early stages of embedding a cultural, people-centred approach to change management. This approach is designed to equip managers and teams with the tools and techniques needed to manage change effectively, with a strong focus on engagement, wellbeing and behavioural change. A Head of Change and People Insights was appointed in January 2025 to lead this work.

The ADKAR model (Awareness, Desire, Knowledge, Ability, Reinforcement) has been adopted as the core framework for managing change. Since 2023, accredited APMG change management training has supported the development of a change community, which had grown to 77 members at the time of audit fieldwork. A comprehensive suite of tools and guidance is available on Siren to support change delivery. The resources promote critical thinking and contextual application rather than prescribe rigid processes. This reflects a shift from command-and-control culture to one based on trust, autonomy and compassionate leadership. While alignment with formal project management is a future goal, the current focus is on embedding core change principles to support cultural transformation.

Senior leadership engagement has been supported through a dedicated change leadership session delivered to the Trust Board in December 2023 by an external facilitator. Awareness sessions have also been delivered as part of the Clinical Model Transformation (CMT) programme. Change management principles are being integrated into the Trust's leadership and management development framework, '*Our WAST Way*'.

Expectations for Change Community Leads have been communicated to their respective Executive Directors, with leads undertaking these responsibilities alongside their substantive roles. The Trust's approach focuses on equipping staff with tools, knowledge, and guidance needed to deliver change effectively within existing resource constraints. Work is ongoing to clarify the roles of Senior Responsible Owners (SROs) and Executive Sponsors to better align change delivery with project and programme management.

The NHS Wales Organisational Change Policy, accessible to all Trust staff via Siren, applies to "*all situations of organisational change, whether these are internally generated service reviews or externally approved mergers or de-mergers"*. The policy prioritises the avoidance of compulsory redundancies and mandates a minimum four-week consultation period for all Organisational Change Processes (OCPs). However, more clarity of OCP arrangements is required. Specifically:

- OCP templates require enhancement and are currently not accessible to staff, increasing the risk of inconsistent application and the use of outdated materials (see **Key Finding 1**).
- Documented guidance outlining the OCP process would help clarify roles and responsibilities (see **Key Finding 1**).

Key Findings		Risk & Impact	Agreed Management Action
1	**Documented Procedures** Several templates have been developed to support the OCP process, covering areas such as the rationale for change, consultation, and feedback. However, these templates are not currently available on the Trust's SharePoint site, leading to inconsistent use and the circulation of outdated versions. Additionally, the templates could be improved to prompt for key elements such as cost implications, resource capacity, and the approval process. There are currently no formal, documented procedures available to guide managers through the OCP process. Although People Services provide support during OCP delivery, the absence of clear guidance has contributed to uncertainty among staff. Feedback from staff involved in sample testing (see **Objective 2**) indicated that some had no prior experience with OCPs, resulting in a lack of clarity around roles and responsibilities, particularly regarding the timing of job description reviews and the completion of Equality and Quality Impact Assessments (EQIA and QIA).	Inconsistent processes and lack of standardised guidance may result in reduced accountability, limited oversight, and variable application of the Organisational Change Policy.	**Agreed Action:** 1. There is an OCP toolkit for Managers, including template letters and standardised templates. However, these aren't stored on SIREN. The People Business Leader would share with the appropriate Manager, to ensure that letters that may change Ts & Cs are not easily accessible without People Services advice. Following feedback from this audit and to raise line manager awareness of the OCP process we will include a Manager's Easy Read Guidance document, and a Manager's checklist, added to SIREN under People Services Toolkits. 2. The All-Wales OCP process is the guide which steps out each consideration, however we will develop a more simplified guide for Managers on the People impact elements to consider- in the form of a flowchart.
			Expected Evidence of Implementation: 1. Manager's Easy Read Guidance Document and a Manager's Checklist of OCP toolkit available on SIREN under People Services Toolkits. 2. Flow chart available on SIREN under People Services Toolkits.
		Medium Priority	**Officer:** (1) Karen Jones, Deputy Head of People Services; (2) Bev Flood, Head of People Services
	Theme: Policies & Procedures	Control Design	**Target Implementation Date:** (1) 31 December 2025; (2) 28 February 2026

Objective 2: Recording, evaluation, approval and delivery of organisational change	**Reasonable**

Overview / Summary of Observations

The Trust reviews its Integrated Medium-Term Plan (IMTP) through a *people-impact lens* to identify areas of organisational change. However, in practice, requests for change management support are typically initiated through People and Culture Business Managers meetings or direct engagement with Directors. While the People and Culture Directorate Plan includes known OCP programmes supported by business partners, it is acknowledged that this does not constitute a complete or reliable source for identifying all OCPs, which impacted the scope and sampling of our audit. A lack of early engagement and planning continues to hinder effective resourcing and coordination of change management (see **Key Finding 2**). Additionally, there is a broader challenge in tracking OCP activity across the organisation (see **Key Finding 3**) which limits oversight and the ability to manage change consistently and strategically.

Audit testing of four OCPs - Advanced Paramedic Practitioner (APP), Volunteers Service, Bryn Tirion relocation, and Putting Things Right (PTR) - confirmed that the rationale and benefits for change were generally well defined. However, interviews with the key staff involved revealed gaps in understanding due to limited prior experience of OCPs. This resulted in uncertainty around roles, responsibilities and the appropriate use of templates (see **Key Finding 1**).

The lack of clarity was particularly evident in the APP and Volunteers Service OCPs, where there was confusion about the appropriate timing of job description reviews. At the time of audit, the Volunteers Service OCP had concluded, but not all revised job descriptions had been finalised. A separate Job Evaluation audit is scheduled for 2025/26, which will consider the broader process.

There were also inconsistencies in the application of Equality Impact Assessments (EQIA) and Quality Impact Assessments (QIA). While organisational guidance exists and the topic was recently discussed at Audit, Risk and Assurance Committee (24 June 2025), alignment with the OCP process needs strengthening (see **Key Finding 1**). Although EQIAs were completed for three of the four OCPs, only the Bryn Tirion EQIA could be confirmed as having been submitted to the Inclusion and Engagement team. QIA completion was inconsistent. While QIAs were completed for the Bryn Tirion and Volunteers Service OCPs, they were either not completed or evidenced for the APP and PTR OCPs, despite the potential for significant clinical or service model changes.

Other variations in OCP management were also noted. For example, the PTR OCP included a business case; while the APP and Bryn Tirion OCPs benefited from project manager support and formal project documentation, which helped strengthen the recording of risks, benefits and milestones. Approval routes also varied across the four OCPs (see **Key Finding 1** and **page 3**).

Appendix 3 of the NHS Wales Organisational Change Policy outlines the management of seconded, acting up, and fixed term employees. However, the Trust currently lacks system controls to identify staff who have been in a temporary post for over four years. An ESR report reviewed during the audit did not clearly provide this information but did highlight one case where ESR had not been updated to reflect a permanent appointment (see **Key Finding 4**).

As noted in **Objective 1**, the wider change management framework is still in the early stages of implementation. While no formal testing was undertaken in this area, discussions confirmed that a dedicated change management workstream exists within the CMT programme. Support from the change community is also being provided across other workstreams - for example, the Head of Change and People Insights and a change community member supported the Bryn Tirion relocation, helping to strengthen communication and engagement.

Key Findings		Risk & Impact	Agreed Management Action
2	**Organisational Change Planning and Co-ordination** Historically, OCP-related activity has been treated as business-as-usual within the Trust. However, the growing volume of transformational change has exceeded existing capacity. At the time of audit, the People & Culture Directorate was managing approximately 100 active cases, including nine OCPs within a single area. Limited visibility of upcoming service-led changes continues to hinder effective resource planning. The NHS Wales Organisational Change Policy defines change as having occurred when it is "*likely to have a significant impact on the nature of the work performed or the arrangements or conditions under which the work is carried out*" (p.7). Despite this, there is currently no mechanism in place to ensure that significant organisational change is consistently planned and co-ordinated across the Trust, particularly in relation to the alignment of change community and People & Culture resources. The People and Culture Directorate Plan records some change management support for 2025/26 (e.g. Ambulance Care and APP), but no entries were available for 2024/25, limiting its use for OCP audit sampling. Audit testing highlighted the following key issues: • **Project Classification:** There is a lack of clarity on when OCPs should be treated as formal projects. This affects the ability to allocate dedicated support, assess risks and timelines at inception; and ensure consistent reporting. • **Experience and Support:** OCP planning does not currently consider whether key individuals have prior experience with the process. A lack of previous experience impacted two of the sampled OCPs, one of which involved a manager, project manager, and trade union representative all new to the process. This contributed to gaps in understanding and inconsistent delivery.	Organisational change is not consistently planned, recorded or managed, leading to inefficient use of resources and potential negative impacts on staff wellbeing due to uncertainty and lack of coordination.	**Agreed Action:** 1. Only large OCPs are recorded on the People and Culture Directorate Plan as OCPs are part of BAU for the directorate and cannot always be forecast or anticipated. The guidance for managers and leaders will include reference to early notification to the People Services Team so better planning and scheduling can be implemented to avoid resourcing issues wherever possible. 2. An OCP tracker will be established so multiple teams across People & Culture can review, update and have better oversight of the OCPs in existence across the organisation. This will lead to better oversight. 3. Project Classification: There are projects which will be led by Project Managers, Planning or SROs, that will have a people impact and some OCPs which only have a people element, e.g. restructures that People Services will support. Where OCPs are part of a project that has a dedicated project manager this is treated as a formal project. Both formal and informal OCPs will be captured on the OCP tracker. 4. Experience and Support: OCP toolkit will be made available on SIREN and People Services support is always available for OCP processes. **Expected Evidence of Implementation:** 1. Manager's Easy Read Guidance Document and a Manager's Checklist of OCP toolkit 2. OCP Tracker in existence (exploration if this can be done using the same software review for case management) 3. Review of OCP Tracker and People and Culture Directorate Plan. All projects captured on OCP Tracker 4. PDF read only copies of OCP toolkit available on SIREN under People Services Toolkits.
		High Priority	**Officer:** (1 to 4) Karen Jones, Deputy Head of People Services; and Bev Flood, Head of People Services **Target Implementation Date:** (1&4) 31 December 2025 (2&3) 31 January 2026;
	Theme: Resourcing	Control Design	

Key Findings		Risk & Impact	Agreed Management Action
3	**Monitoring and Reporting Organisational Change** There is currently no robust mechanism in place to track OCPs across the Trust, nor are there independent checks to confirm effective application. This limits the ability to confirm whether change is being managed consistently, with appropriate oversight and opportunities for continuous improvement. While our testing of four OCPs found that trade union representatives were actively keeping their counterparts informed, there is opportunity to strengthen governance arrangements. In particular, more formalised reporting of organisational change at a trade union level would enhance transparency and support more consistent engagement.	In the absence of a robust mechanism to monitor and report organisational change, there is a risk that change initiatives are not managed consistently, reducing opportunities for oversight, learning, and continuous improvement. This may also limit transparency and formal engagement with key stakeholders, including trade union representatives.	**Agreed Action:** 1. An OCP tracker will be established so multiple teams across People & Culture can review, update and have better oversight of the OCPs in existence across the organisation. 2. A quarterly review of OCPs in progress and completed will be undertaken to include lessons learned and benefits realisation. 3. A high level OCP update will be provided at Corporate Partnership Forum (CPF) for activity relating to that Directorate to ensure Trade Union awareness (OCP details will not be subject to discussion at the Local Partnership Form (LPF) meetings due to potential issues regarding confidentiality)
			Expected Evidence of Implementation: 1. OCP Tracker in existence 2. Quarterly reviews completed 3. Minutes of CPF meeting
		Medium Priority	**Officer:** (1 to 3) Liz Rogers, Deputy Director of People & Culture Directorate; and Bev Flood, Head of People Services **Target Implementation Date:** (1) 31 January 2026; (2) 1 April 2026; (3) 28 February 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Key Findings		Risk & Impact	Agreed Management Action
4	**Temporary Appointments** The NHS Wales Organisational Change Policy (p.27) states that "*Where an employee has been seconded or acted up in a post for a period of four continuous years or more, on the date on which they are displaced this will be considered to be their substantive post*." However, there is no robust mechanism in place within the Trust to monitor the duration of temporary appointments. While it is expected that job role reviews during restructures will identify such cases, responsibility for monitoring rests with individual line managers. As part of our audit, we obtained a system-generated report from ESR; however, it did not clearly identify employees who had been in temporary posts for more than four years. We noted one case where an employee's temporary post began on 9 March 2020. We have since been advised that this individual was appointed on a permanent basis in December 2021, but the ESR system has not been updated to reflect this change.	Change requests are not effectively monitored or updated, leading to incorrect employee data, reduced data integrity and potential non-compliance with organisational policies.	**Agreed Action:** 1. Approval from Recruitment Control Panel (RCP) for temporary/FTC/secondment appointments will be dip sampled using TRAC and ESR to establish if change requests are being managed effectively. 2. Reminder to LMs/recruiting managers about the need to ensure that ESR holds the correct employment status of team members will be communicated via SIREN. 3. Quarterly reporting for temporary/FTC/secondment appointments and reviewed by People Service Team and Workforce Planning Team.
			Expected Evidence of Implementation: 1. Dip sampling has taken place. 2. Notice on SIREN 3. Quarterly report
		Medium Priority	**Officer:** (1 & 2) Liz Rogers, Deputy Director of People & Culture Directorate
	Theme: Information, Data Quality & Data Accuracy	Control Design	**Target Implementation Date:** (1) 31 March 2026; (2) 31 December 2025 (3) 1 April 2026

Objective 3: Stakeholder identification, engagement, consultation and support	**Reasonable**

Overview / Summary of Observations

IMTP 2025-28 reporting to Trust Board (24 March 2025) highlighted that 47% of Trust respondents to the NHS Wales staff survey did not feel involved in changes affecting their work, area, team or department. This indicates a need to continue developing the organisation's change culture and to strengthen change support and capability.

Documented guidance is available to support stakeholder engagement and consultation. The Change Management Playbook, accessible via Siren, prompts for stakeholder identification and includes a communication plan template to map milestones. An OCP template also exists to outline consultation processes, timeframes, and employee support; however, as noted in **Key Finding 1**, this template is not currently accessible to staff.

Audit testing of four OCPs (APP, Volunteers Service, Bryn Tirion relocation, and PTR - see **Objective 2** and pages 3-4) found generally positive engagement and consultation practices, including:

- Early engagement with affected staff prior to formal OCP initiation.
- Trade union involvement at key stages.
- Clear documentation of consultation processes, including formal notices and adherence to the four-week consultation period (except PTR, where a three-week period was agreed with staff and unions).
- For Bryn Tirion, regular project board updates and a FAQ document supported ongoing communication.

However, inconsistencies were noted in how consultation feedback was recorded:

- The APP OCP used the feedback template to document management responses to employees' concerns.
- The Volunteers Service manager was unaware of the template but still recorded outcomes.
- PTR incorporated feedback into an updated consultation document rather than using the template.
- For Bryn Tirion relocation, there was no formal documentation completed to evidence that no relevant feedback was received in relation to the OCP (see **Key Finding 1**).

Objective 4: Governance framework and opportunities for continuous improvement and learning	**Reasonable**

Overview / Summary of Observations

Recognising the need to strengthen governance arrangements, the Trust has developed an integrated governance map, approved by the Audit, Risk and Assurance Committee in March 2025. This map sets out key principles to support effective oversight and accountability across meetings; clarify roles and responsibilities; and improve meeting administration.

The dedicated change management workstream, part of the CMT programme, sits within the Strategic Development and Delivery Arm of this framework. Terms of reference are in place and AAA (Alert, Advise and Assure) reporting has been evidenced to the CMT Programme Board. Challenges regarding SRO attendance at workstream meetings have been escalated through IMTP reporting to the Trust Board and its committees.

The change community is a developing, informal forum within the wider change management process. It supports cultural change through trust, connection, and shared learning, without formal structures or governance. Monthly meetings provide an opportunity for colleagues to engage and build confidence. The Trust has made a significant investment in this network to strengthen change capability and support while enabling sustainable improvement across the organisation. It is too early to assess the impact of this new approach, but this will need to be considered in the longer term.

Our testing (see **Objective 2** and **pages 3-4**) found positive evidence of OCP monitoring and reporting. For example, the APP OCP reported regularly to the Advanced Clinical Practice Delivery Group (ACPDG), and the Bryn Tirion relocation OCP had an established project board. Broader updates on OCP progress and change management were also reported to the Trust Board and its committees. However, the Trust may wish to consider formalising the reporting of OCPs within its trade union structures (see **Key Finding 3**).

The Terms of Reference for the People & Culture Committee state that it will "*receive and consider projects of major strategic organisational change where there is a significant impact on people's health and wellbeing, and cultural change*". While we observed evidence of reporting to the Committee, as noted in **Key Finding 2**, further clarification is needed to ensure consistent classification and reporting of OCPs as formal projects.

Two OCPs (APP and Bryn Tirion) considered lessons learned and benefits realisation as part of their project management processes. However, only the APP OCP had formally recorded lessons learned and established a mechanism for capturing benefits. Consideration should be given to how OCPs will be assessed post-implementation (see **Key Finding 5**). The absence of a post-implementation review and benefits assessment was also raised in our Emergency Communication Nurse System review.

Organisational learning is a key enabler of the Trust's broader cultural ambition to create a more reflective, adaptive and people-focussed organisation. Within this culture, teams and individuals are encouraged to reflect regularly, provide meaningful feedback and consider the change impact on people. The inclusion of an *"Action Replay"* tool in the change management guidance prompts for critical reflection and to capture lessons learned. Additionally, the Trust is in the process of implementing, a new platform, Simply Do, to support data capture, knowledge sharing and continuous improvement. We also note that early conversations are being held with colleagues in the Quality Improvement team to explore closer alignment and mutual reinforcement of their respective agendas, with a view to create more opportunities for cross-learning and shared reflection.

Key Findings		Risk & Impact	Agreed Management Action
5	**Organisational Learning** Our review of sampled OCPs identified varying approaches to capturing lessons learned and benefits realisation: • APP: As a formal project, APP maintained a lessons learned log; however, this has not been widely shared. A populated benefits register exists, though it was considered too early to record benefits realisation. Initial post-implementation feedback was gathered, with a further session planned for September 2025. • Volunteers Services: No lessons learned, or benefits realisation have been recorded to date. A six-monthly review of the reconfigured service is, however, planned. • Bryn Tirion Relocation: The Project Initiation Document references post-project evaluation and lessons learned. While lessons were discussed at the May 2025 Project Board, they have not been formally documented. Similarly, no benefits realisation has been undertaken. • PTR: No formal documentation of lessons learned, or benefits realisation was identified. While consultation outcomes indicate that reviews of the operating model are planned at six- and twelve-months post implementation, we were advised that these discussions have occurred informally at team meetings and have not been formally recorded. Currently, there is no structured process in place to prompt or support the consistent recording and sharing of lessons learned of benefits realisation across OCPs.	A lack of structured organisational learning processes may result in missed opportunities for improvement, reduced knowledge transfer, and sub-optimal decision making.	**Agreed Action:** 1. Formal projects will continue to review lessons learnt and benefits realisation as part of the formal project management process. Those involved (People & Culture/Business areas/TUPs) in an OCP process will undertake reviews on a quarterly basis to review the effectiveness of the OCP processes in train and completed; and consider opportunities for continuous improvement as well as the realisation of benefits. This will be supported by a checklist. 2. Whilst our approach is primarily culture and capability focussed, rather than process driven, we recognise the importance of being able to evidence benefits and lessons learned. We will be documenting lessons learned through change initiatives and sharing these widely through a case study approach, highlighting practical examples of people focused changed and the impact on individuals, teams and outcomes. These case studies will be made available through our Change Community and other internal channels (including the CMT Change Management Workstream) helping to spread good practice, prompt reflection and inspire local adaptation. As a tangible measure of impact, we will also monitor relevant NHS Wales Staff Survey indicators to help track cultural shifts over time. This will be supplemented by qualitative feedback gathered through our engagement activities. **Expected Evidence of Implementation:** 1. Checklist completed 3 months post OCP. 2. Document lessons learned via case studies, share widely across the organisations and track impact through relevant staff survey indicators – *23d: I am involved in deciding on changes introduced that impact my work/area/team/department*
		Medium Priority	**Officer:** (1) Liz Rogers, Deputy Director of People & Culture Directorate; (2) Sarah Davies, Head of Change & People Insights **Target Implementation Date:** (1) 1 April 2026 (2) 31 March 2027 (recognising these shifts take time; and will allow comparison of 2024,2025 and 2026 Staff Survey results)
	Theme: Lessons Learnt	Control Design	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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.

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

Agenda Item No.	06.3

REPORT TITLE

Proposed Change to 2025-26 Internal Audit Plan

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	2 September 2025
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	Trish Mills, Director of Corporate Governance/Board Secretary

PURPOSE OF REPORT

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

REPORT SUMMARY:

1. Following a review of the Internal Audit programme for this year, it is proposed that Clinical Prioritisation and Assessment Software (CPAS) Group (the governance and workflow) is audited in place of the planned Remote Clinical Support review, due to the number of high-

level changes currently flowing through CPAS with the implementation of the Clinical Model Transformation.

2. It is proposed to postpone the Remote Clinical Support audit to Q1 in next year's Internal Audit programme.

3. It will be recommended to the auditors that the following areas are reviewed to ensure that this is a robust and fit for purpose process that underpins the Trust's Clinical Transformation:

    - Dispatch Cross Reference (DCR) Table Change Management Policy
    - the Request for Change process,
    - the record keeping of changes for enquiries (incl. coronary inquest), and
    - the CPAS governance structure.

RECOMMENDATION(S)

The Committee is requested to:

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

ADDITIONAL PAPER(S)

1. 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, the Directorate risk surrounding CPAS is being mitigated by requesting Internal Audit review the governance process for this area of work.

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
28.07.2025	Clinical Directorate Business Meeting
13.08.2025	Agreed programme change with Operations colleagues
27.08.2025	Change approved by Executive Leadership Team

Archwilio Cymru
Audit Wales

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

Date issued: August 2025

Document reference: 4959A2025

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

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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 as described above. Audit Wales is not a legal entity and itself does not have any functions.

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Contents

Audit, Risk, and Assurance Committee update:

About this document

1 This document provides the Audit, Risk, and Assurance Committee with an update on our current and planned accounts and performance audit work at the Welsh Ambulance Services University NHS Trust. We presented our detailed 2025 Audit Plan to the committee on 1 May 2025.

2 We also provide additional information on:

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

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Current status
Audit of the Trust's 2024-25 Financial Statements	Executive Director of Finance and Corporate Resources	Audit work is complete, and our closing 'Audit of Accounts Report' has been issued. The accounts were certified by the Auditor General on 27 June 2025 and laid with the Senedd shortly afterwards.

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of Unscheduled Care	Executive Director of Operations	This work examined different aspects of the urgent and emergency care system in three parts: • Part One: Flow out of hospital (not applicable to the Trust). • Part Two: accessing urgent and emergency care. • Part Three: national arrangements and leadership structures.	Part Two: Complete Part Three: Planning	December 2025
Structured Assessment deeper dive - Review of	Director of Digital Services	This audit will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the	Fieldwork	December 2025

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

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

Audit Committee Update

Other relevant publications

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

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

Title	Publication Date
Cost Savings Arrangements: A Checklist for NHS Board Members	June 2025
No time to lose: Lessons from our work under the Well-being of Future Generations Act	April 2025
The Biodiversity and Resilience of Ecosystems Duty	March 2025

Additional information

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

8 There is one consultation underway on the Audit Wales Fee Scheme for 2026-27. Further details are available here.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Annual Report and Accounts 2024-25	June 2025
Annual Plan 2025-26	April 2025

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

AGENDA ITEM No	**15**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**5**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit, Risk and Assurance Committee
DATE	02 September 2025
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

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

   Risk Management Work Programme 2025/26

2. The 2025/26 work programme is progressing with several key elements already complete – the high level detail of these is included in paragraph 18. The detailed update on progress and plans is drawn out throughout the report. This includes work on the development of a suite of Risk Appetite statements, recruitment of a Risk Manager, continued work to reposition the Trust's highest rated Risks 223 and 224, an electronic risk management solution and the future for strategic risk and the strategic Board Assurance Framework (BAF).

3. As agreed with committee at the last meeting in June 2025, the team will continue to exercise flexibility to adjust timings and outputs as new ways of working are explored. Regular updates will continue to be provided to ARAC for oversight as the work progresses.

4. The six draft Risk Appetite statements (RAs) will be presented at the next Board Development Day on 19 September 2025 for consideration ahead of formal approval by the Trust Board.

5. The third round of recruitment for a Risk Manager was completed and we welcomed Dan King to the team, and he commenced post on 11 August 2025.

Repositioning Risks 223 and 224

6. Work has continued to review the Trust's highest rated Risks 223 *the Trust's inability to reach patients in the community causing patient harm and death* and Risk 224 *significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service*, in detail and implement a new approach to the way these risks are presented.

Board Assurance Framework

7. As highlighted during the programme of effectiveness reviews, Members acknowledged that reporting of current, principal risks contained in the Board Assurance Framework (BAF) are effectively reported and scrutinised at board and its committees.

8. A summary table of the Trust's principal risks is set out at Annex 1 with a detailed description contained within the Board Assurance Framework (BAF). All updates are highlighted in blue.

9. The BAF has been included in the reading room facility in Ibabs, which is a digital space that hosts documents. Access to the reading room is through the documents/shared folder in Ibabs' main menu. For those without access to Ibabs, the BAF is available on the Trust's website alongside this meeting's papers.

10. This document has been included in the reading room given its significant size and the fact that it has been reviewed by each of the committees during this quarter. Any changes to principal risks have been drawn out within this report.

11. The more detailed description contained within the BAF provides committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the scoring matrix in Annex 2.

12. Members can take assurance that each of the principal risks have been reviewed in line with the agreed schedule detailed at Annex 3 and that the Executive Leadership Team (ELT) approved the principal risk activity on 09 July 2025 having considered the review of each risk undertaken throughout June 2025 by Risk Owners and the Assistant Director Leadership Team (ADLT).

13. A dashboard describing risk score trends and movement over time (Annex 1) has been produced which and will be included in the committee risk reports where relevant to their remit.

14. This report and the risk management work programme outline the significant work undertaken, to keep under review, the Trust's principal risks, which are before committee today for scrutiny.

15. There have been no material changes to the principal risks during this period; however, each of the Committee AAAs were presented to the Board on 31 July 2025 and described the discussions against risks within their remit. Additionally, the BAF includes a commentary for each risk for the Risk Owner to describe the rationale for each of the risk ratings which is particularly important where ratings have remained static or increased.

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

16. The outline programme of work includes:
    - June 2025: Continued work on repositioning Risks 223 and 224 *(Ongoing)*
    - July 2025: Anticipated appointment of a Risk Manager to the team *(Complete)*
    - July 2025: Electronic Risk Management system demos *(Complete)*
    - August 2025: Finalise Risk Appetite Statements (RAs) *(Complete)*
    - September 2025: Sign off RAs by ARAC and the Trust Board *(Scheduled)*

<u>Risk Management Policy</u>

17. Members are asked to endorse the Risk Management Policy which has been reviewed with no material changes made to the Policy this year. The next review is scheduled for September 2026 and will be updated to reflect any amendments to the Trust's risk management processes.

RECOMMENDATION:

18. Members are asked to receive assurance on progress of the 2025/26 Risk Management work programme and timelines, and:
    a. Note that the six draft risk appetite statements will be considered at the Board Development Day on 19 September 2025.
    b. Endorse the Risk Management Policy for approval by Trust Board.
    c. Note the continued work on repositioning of Risks 223 and 224.
    d. Receive assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant committees.
    e. Note the ratings and mitigating actions for each principal risk.

KEY ISSUES/IMPLICATIONS
The key issues and implications are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
Each of the Principal Risks have been or are due to be considered by the following Committees, as relevant to their remit, during the forthcoming reporting period: • Executive Leadership Team (09 July 2025)

- Assistant Directors Leadership Team (21 July 2025)
- Finance & Performance Committee (22 July 2025)
- Trust Board (31 July 2025)
- Quality, Safety & Patient Experience (05 August 2025)
- People & Culture Committee (12 August 2025)
- Audit, Risk and Assurance Committee (02 September 2025)

REPORT ANNEXES
Annex 1 - Summary table describing the Trust's Principal Risks. Annex 2 – Scoring Matrix Annex 3 – Frequency of Risk review Annex 4 – Principal risk trending data Annex 5 – Risk Management Policy

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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The report has several elements, firstly to provide an update on the risk management work programme for 2025/26, secondly, assurance in respect of the management of the Trust's principal risks and finally to present the Risk Management Policy for endorsement ahead of Trust Board approval.

BACKGROUND

2. The Risk Management programme is reported and monitored through the Corporate Governance Directorate's Directorate Plan and to the Audit, Risk & Assurance Committee (ARAC) for oversight.

3. The direction of travel and next steps for this year's work programme was presented in detail to and supported by the Executive Leadership Team (ELT) and Committee in September 2024 and reinforced by the recommendations made by our external consultants, BDO in their report.

4. This is in addition to a substantial programme of work to be undertaken with respect to the next stage of our enterprise risk management, as highlighted in the 2023/24 Internal Audit Review.

5. Principal risks are allocated to appropriate Directors to drive the reviews and actions to mitigate the Trust's principal risks. In addition to directorate reviews there are formal risk review discussions with the Assistant Directors Leadership Team (ADLT) and the ELT in relation to risk escalation, changes in ratings, and any new risks for inclusion on the Corporate Risk Register (CRR).

6. This report highlights the focus that is maintained on management of these risks, not only because of risk discussions in the various forums but also because of broader attention to planned mitigations across the system.

ASSESSMENT

<u>Risk Appetite Statements</u>

7. Work has continued to develop a suite of Risk Appetite statements (RAs) which will define the level of risk that the Trust is willing to take or accept in pursuit of its strategic objectives. This is to ensure better outcomes for our patients, our people and communities and in working with our partners and stakeholders.

8. There are six RAs aligned to the Trust six strategic objectives as outlined in the Long Term Strategy: Delivering Excellence 2030.

9. The Trust Board has already considered RAs 1-4 and the team attended the Strategic Transformation Board on 11 August 2025 to finalise the remaining two; RA5 and RA6 ahead of a further discussion on these at the Executive Leadership Team on 27 August 2025.

10. Overall, the Trust is *open* to embrace more risk and opportunities to enhance our service delivery, achieve significant improvements in our people's capabilities, pursue advancements in innovation and technology, to collaborate with other partners to develop services, to embrace new clinical practices and quality initiatives and to enhance our service offerings and overall value.

11. All six draft RAs demonstrating the detail of what it means to take more risk and opportunity in each of these areas will be shared with the Trust Board for comment in readiness for the session planned at the Board Development Day on 19 September 2025. Following this, the Board will be asked to agree and set the appetite against each of the Trust's six strategic objectives.

12. Once the Board have formally signed these RAs off, this will address the one outstanding Internal Audit recommendation, action 596, which was due to be completed in March 2025.

13. The next steps for the Risk Appetite statements will be included in the 2026/27 programme of work and will be scoped out to include:

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

14. Following this, the team will develop and pilot one or two strategic risks against the strategic objectives.

15. Work is progressing on the strategic BAF which will be a focus of 2025. The team is keen to continue to work with external consultants to share knowledge and expertise on this and a proposal is being worked through in terms of timelines and cost.

16. A draft front cover of the BAF will be developed for discussion at ARAC; the goal being to provide assurance to the Board that the key risks to the strategic objectives are being managed effectively.

17. Additionally, this will provide the Board with a clear and comprehensive view of both the strategy and what good looks like in 2028, and the strategic risks which will support effective and strategic decision making.

18. Discussions are underway as the metrics are developed to measure the 'what good looks like' in the IMTP; it is important to consider what the risks are to achieving these as the two go hand in hand. This work will support the development of the strategic BAF in a more focused and meaningful way; however, the team will be exploring new ways of working and require the flexibility to adjust timings and reporting to ARAC as the work progresses.

Principal Risks

19. The principal risks have been reviewed in line with the agreed schedule detailed at Annex 3 and the Executive Leadership Team (ELT) approved the principal risk activity on 09 July 2025 having considered the review of each risk undertaken throughout April and May 2025 by Risk Owners and the Assistant Director Leadership Team (ADLT).

20. Each of the risks have been reviewed with a continual and dynamic focus on the highest rated risks scoring 15-25. Attention has been given to the risk ratings of each principal risk and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the standard and regular review of all controls, assurances, and any gaps.

21. A dashboard describing principal risk score trends and movement over time has been produced and is attached at Annex 4. A heat map of these risks will be developed once work commences to map these risks to the overarching strategic risks in development; those that will prevent the Trust from achieving its strategic objectives.

22. The trend data demonstrates that where a risk has achieved target or been fully mitigated then these are either removed from the corporate risk register or de-escalated to directorate risk registers for ongoing monitoring.

23. The Trust's highest rated **Risks 223** *the Trust's inability to reach patients in the community causing patient harm and death* and **Risk 224** *significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service*, remain static at the highest score of 25. The score is not based on the volume of cases of catastrophic harm; it is based on any one individual that experiences

avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing delays in the way in which they currently are.

24. Whilst reducing, handover delays continue to present patient safety risks and extended waits in the community with a deteriorating performance impact being outside of what is acceptable to deliver a safe emergency service.

25. The number of lost hours due to handover delays remained significant reported at 19,673 in May and 15,276 in June. That said, the drop in handover lost hours in June and onwards into July, demonstrates some improvement across key hospital sites in reducing handover delays. Whilst this marks positive and welcome progress towards the 45-minute handover ambition, this downwards trajectory must continue to be sustained over a longer period of time prior to any consideration of a reduction in risk score.

26. Phase one of the Trust's Clinical Transformation Model - specifically the introduction of Code Changes for response - has now gone live, representing a key milestone in the delivery of an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. In parallel, early adoption of the Wait 45 handover standard by some Health Boards represents a positive step toward reducing avoidable patient harm by supporting more timely transfers of care and improving the overall experience for patients awaiting treatment.

27. The risks continue to be reported to the Trust Board, with a focus on the actions to mitigate these two risks that are within its control, and these are highlighted in the avoidable harm dashboard which is presented at each Board meeting. Further mitigations and transformative actions are described in the Integrated Medium Term Plan (IMTP) and are presented to committees and Trust Board in a variety of reports e.g. IMTP Assurance Report and described in the Monthly Integrated Quality & Performance Report to address these risks.

28. Most of the Trust's actions in the avoidable harm dashboard have been completed and a several efficiencies and improvements implemented that have stabilised performance; however, the Trust is unable to completely mitigate the scale of handover lost hours due to the environment which it is operating in.

29. Work has continued since the last meeting to undertake detailed reviews of these highest scoring risks with members of the Risk Owner's senior teams. This work is described from paragraphs 37 onwards and members are asked to note that there is still work to be done on both documents.

30. The Quality, Patient Experience and Safety Committee (QuEST) reviewed both risks at its meeting in August 2025 with the Agenda items reflecting the controls

and mitigations discussed at this meeting. These risks continue to be escalated to the Board via the meeting's Alert, Assure and Advise (AAA) report.

31. **Risk 160** *High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service*, is rated 20 (5x4). This risk has had an in depth review at several forums and it is likely that the score will decrease in the next round.

32. **Risk 201** *A loss of stakeholder confidence that damages the Trust's reputation*, remains static at a score of 20 (4x5) given that many of the mitigations are outside the Trust's control. The risk was discussed at the last People & Culture Committee on 15 May 2025 and the tension in the reputational risk was noted that while the Trust has positive relationships with stakeholders, the patient experience remains poor due to harm in the community. A deep dive will be conducted on the risk over the summer to consider splitting it into a stakeholder risk and a patient experience reputational risk. This approach aims to address the different aspects of reputation and ensure the risk is accurately profiled.

33. **Risk 260** *A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems* remains static at a score of 20 (4x5) due to the escalated world conflicts and recent increase in targeted cyber-attacks against NHS organisations. 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 the overall risk dashboard for open session; however, the full detail is not included in Annex 4. The risk is included for discussion in closed session of ARAC today and was considered by the closed meeting of the Finance & Performance Committee (FPC) on 22 July 2025.

34. **Risk 641** *The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident* remains static at a score of 20 (4x5). This risk is taken in open session of the Board in full transparency. However, members will note that the actions to address individual recommendations are not included in detail in the BAF extract. This is for reasons of sensitivity and security.

35. **Risk 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* remains static at a score of 16 (4x4). This risk was discussed in detail at the FPC on 20 May 2025 and a meeting with FPC Non-Executive Directors and the risk owner and risk team has taken place to consider repositioning the risk and a new approach to the way this is presented. The new approach separates controls, assurances and gaps into internal and external

themes and categories; those that the Trust manages and those that it monitors. Each of the assurances against the controls will be described over three lines of assurance.

36. **Risk 558** *Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures,* **Risk 594** *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* and **Risk 623** *Failure to comply with Data Protection Legislation* all remain unchanged this period and static at a score of 15 (3x5). The Welsh Ambulance Services Partnership Forum (WASPT) held a deep dive on **Risk 558** at its July 2025 meeting.

37. **Risk 100** *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* and **Risk 163** *Maintaining Effective & Strong Trade Union Partnerships* remain unchanged at a score of 12 (3x4). The WASPT undertook a detailed review of this risk at its meeting on 30 May 2025 and it was agreed that the risk was appropriately scored and highlighted the evolving nature of partnership working. Since March 2023, risk scoring trends (Annex 5) have reflected challenges - some stemming from industrial action. However, current partnership working is on a much stronger footing, with clear articulation and demonstration of how social partnership should operate at the Trust.

38. **Risk 139** *Failure to Deliver our Statutory Financial Duties* remains unchanged at a score of 8 (2x4) during this period; however, the Executive Director of Finance and Corporate Services has foreshadowed that this risk is likely to increase in the near future given the financial position.

<u>Repositioning of Risks 223 and 224</u>

39. Work has continued since the last meeting on the design and development of a different approach to presenting these risks which separates controls, assurances and gaps into internal and external themes and categories.

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

41. The way the data is being presented in themes and categories supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level in the same way that this is done for other risk such as the Manchester Arena Inquiry and Cyber Security Risk.

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

Risk Manager Recruitment

43. Successful interviews were held for the position of Risk Manager on 11 July 2025. The team welcomed Dan King who commenced post on 11 August 2025.

Electronic Risk Management System

44. The Trust's team continue to explore options for a new digital solution. This work will form part of the new Risk Manager's portfolio. By way of assurance for committee; the Trust will remain on the current Datix Risk Web module at no additional cost until November 2027.

Risk Management Policy

45. Members are asked to endorse the Risk Management Policy which has been reviewed with no material changes made to the Policy this year. The next review is scheduled for September 2026 and will be updated to reflect any amendments to the Trust's risk management processes.

RECOMMENDED

46. Members are asked to receive assurance on progress of the 2025/26 Risk Management work programme and timelines, and
    a. Note that the six draft risk appetite statements will be considered at the Board Development Day on 19 September 2025.
    b. Endorse the Risk Management Policy for approval by Trust Board.
    c. Note the continued work on repositioning of Risks 223 and 224.
    d. Receive assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant committees.
    e. Note the ratings and mitigating actions for each principal risk.

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death.	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Executive Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service.	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Executive Director of Quality & Nursing	**25 (5x5)** →
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service.	**IF** there are high levels of absence **THEN** there is a risk that there is a reduced resource capacity **RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of People & Culture	**20 (5x4)** →
201 PCC	A loss of stakeholder confidence that damages the Trust's reputation.	**IF** there is an inability of the Trust to deliver its core services because of system or organisational pressures **THEN** there will be a loss of stakeholder confidence in the Trust **RESULTING IN** a lack of stakeholder support for the Trust's long term	Director of Partnerships & Engagement	**20 (4x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny		
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems.	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**20 (4x5)** →
641 FPC	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	**IF** the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared **THEN** there is a RISK that the Trust's Incident Response will be suboptimal **RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability	Executive Director of Operations	**20 (4x4)** →
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	**IF** there is a lack of resources and available technology and infrastructure **THEN** there will be a failure to deliver the commitments outlined in	Executive Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		the action plan and within the Welsh Government timelines **RESULTING IN** negative environmental and social impacts causing and reputational damage		
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	**IF** significant internal and external system pressures continue **THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST **RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of People & Culture	**15 (3x5)** →
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Executive Director of Operations	**15 (3x5)** →
623 FPC	Failure to comply with Data Protection Legislation	**IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality **THEN** the Trust will breach its legal obligations and potentially cause	Director of Digital Services	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		the personal or sensitive data to be compromised, lost, or inappropriately used **RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.		
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.	**IF** WAST fails to persuade JCC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered	Executive Director of Strategy Planning & Performance	**12 (3x4)** →
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	**IF** the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained **THEN** there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised **RESULTING IN** a negative impact on colleague experience and/or services to patients.	Director of People & Culture	**12 (3x4)** →
139 FPC	Failure to Deliver our Statutory Financial	**IF** the Trust does: • not achieve financial breakeven and/or	Executive Director of Finance &	**8 (2x4)** →

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

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	oderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	ocal media coverage - short-term reduction in public confidence/trust. hort-term negative social media. ublic 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

Assurance Committee	(All)

Sum of Current risk score			Period									
Directorate	Risk ID	Risk Title	Mar-23	Jul-23	Sep-23	Nov-23	Mar-24	Jun-24	Sep-24	Nov-24	Mar-25	Jul-25
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
	623	Failure to comply with Data Protection Legislation						15	15	15	15	15
	543	Major disruptive incident resulting in a loss of critical IT systems	15	15	15	15	15					
Finance and Corporate Resources	139	Failure to Deliver our Statutory Financial Duties in accordance with legislation	16	16	16	16	8	8	8	8	8	8
	542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan						16	16	16	16	16
	458	A confirmed commitment from JCC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	16	16	16	16	16					
Operations	223	Trust's inability to reach patients in the community causing patient harm and death	25	25	25	25	25	25	25	25	25	25
	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
	641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident									20	20
	245	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	16	8								
	244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	12									
Partnership and Engagement	201	Damage to Trust reputation following a loss of stakeholder confidence	20	20	20	20	20	20	20	20	20	20
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
	163	Maintaining Effective & Strong Trade Union Partnerships	12	16	16	16	20	16	16	12	12	12
	558	Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures	15	15	15	15	15	15	15	15	15	15
	557	Potential impact on services as a result of Industrial Action	16	16								
Quality & Nursing	224	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	25	25	25	25	25	25	25	25	25	25
	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						
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
	424	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	12	16	16	16	16	12	8			
	283	Failure to implement the EMS Operational Transformation Programme	12	12	12	12	12					

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

Risk Management Policy

Policy Number:	107	**Version No:**	V2.0 (2025)	**Supersedes:**	V1.0 (2024)
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.
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
Audit, Risk & Assurance Committee	02/09/25	For Endorsement
Trust Board	TBA	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 by emailing AMB_Policies@wales.nhs.uk

CONTENTS

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 risks will inevitably occur while providing the right care and treatment to patients at the right time, as well as in enabling and empowering our staff, managing its finances and resources, and striving to continue to be a quality driven and innovative service.

Risk appetite is defined as the amount and type of risk that the Trust is prepared to take in pursuit of its strategic objectives. It enables the Trust to strike the balance between innovation or opportunities and the threats that are an inevitable part of delivering any service.

The Trust's Risk Appetite should be aligned to its long-term strategy (Delivering Excellence 2030) to enable the organisation to prioritise those risks that are most relevant to achieving its objectives.

The Board is committed to developing a suite of Risk Appetite statements within its risk transformation programme, as essential components of the Trust's risk management framework. These will set out and describe the level of acceptable risk that it is willing to take in pursuit of better outcomes for our patients and local communities as well as for our staff and in working with our partners and stakeholders.

This will be achieved by considering the external and internal environments that it operates in, by establishing a positive risk culture and ensuring a robust risk management framework is in place to monitor, manage and mitigate risk. The result will be the provision of a framework for managers to operate within that includes a risk-based approach to decision making at all levels of the organisation.

Decisions on accepting risks may be influenced by the following:

- The likely consequences are insignificant and/or the risk has a very low possibility of occurring.
- A higher risk consequence is outweighed by the chance of a much larger benefit if the risk is appropriately managed.
- The potential financial costs of minimising the risk outweigh the costs that would arise if the risk event occurred.
- Treating the risk may lead to further unacceptable risks in other ways.
- It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risks or all other alternatives, including doing nothing, is even greater.

Whilst risk is inherent in many of the Trust's activities, it has zero appetite to accept risks that materially impair the ability to deliver services to a high standard of safety and quality including physical and/or psychological harm) of its patients, workforce, and the public, and its reputation or those that may cause any loss of confidence with its stakeholders.

The Trust may accept some risks if the cost of mitigation is too high or if the risk is deemed to be within acceptable limits. In such circumstances, ongoing monitoring is essential to detect any changes and prompt a reassessment of the risk.

3.5. 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.

3.6. The Trust's Strategic Objectives

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

3.7. 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	• 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

	• NIS Toolkit • Annual report • Equality impact assessments • Welsh language standards compliance • Governance codes • PIRs • Systems of integrated governance	• Llais • Various Commissioners • Public service ombudsman • HSE

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.

AGENDA ITEM No	**9**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**0**

2025/26 COMMITTEE EFFECTIVENESS REVIEWS UPDATE

MEETING	Audit, Risk and Assurance Committee
DATE	2 September 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary
CONTACT	Trish.Mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. Following the 2024/25 committee effectiveness reviews, ARAC identified a number of opportunities to streamline the Trust's governance structure. While the delegated responsibilities across committees were deemed appropriate, opportunities existed for reassessment. This briefing provides an update on this work.

2. The approach is driven by several concerns, including the transitional status of the Academic Partnerships Committee (APC) following the achievement of University Trust Status, the desire to increase Non-Executive Director (NED) numbers in meetings (particularly for quoracy purposes), and the sheer volume of meetings - currently a minimum of 52 ordinary open and closed meetings of the board and committees per year.

3. A project plan was developed to explore a more strategic, proportionate and aligned committee framework. The overarching aim is to ensure that the Trust's governance arrangements continue to evolve and be fit for purpose, enabling the board and its committees to discharge their responsibilities effectively while reducing duplication and administrative burden.

4. The review has taken a structured approach by mapping each strategic objective to the most appropriate committee, using the IMTP's definition of "what good looks like" as a guiding framework. This ensures that committees are not only aligned to strategic themes but are also positioned to drive progress, monitor strategic risks, and respond to emerging priorities. The six Delivering Excellence strategic objectives (SOs) are:

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

5. ARAC's role is pivotal in this context. As the committee responsible for ensuring robust governance structures, risk management and internal controls, ARAC provides the foundation upon which the Board is assured that the Trust is positioned to deliver its strategic objectives.

6. Early thinking in the mapping exercise indicates that changes are unlikely to be proposed to the Charity and the Remuneration Committees. These committees are not directly aligned to strategic objectives but are governed by their own frameworks and have demonstrated effectiveness in recent reviews. With respect to the People and Culture (PCC) and QUEST Committees they align well with SO2 and SO5 respectively therefore little material change is anticipated to these.

7. The Finance and Performance Committee (FPC) and ARAC are the focus of the most significant proposed changes. FPC currently oversees the majority of strategic objectives (SO1, SO3, SO6 and to some extent SO4), and its alignment with commercialisation suggests it may be well positioned to take APC's remit around research and innovation. However, further consideration is needed to understand the impact of any changes on FPC's already substantial agenda. In particular, any potential shift in delegations to ARAC must be carefully evaluated to ensure that its critical role in providing independent assurance to the Board on internal controls and the robustness of governance arrangements in support of strategic delivery is not compromised.

8. In the interim, it is proposed that APC continue to oversee the research portfolio through 2025/26, with a meeting scheduled in October and one further to be confirmed to maintain oversight and support the embedding of the Health Care Research Wales research governance framework. This will also provide a forum for showcasing research developments to the board.

9. An updated skills mix for board members is underway, and any changes to the committee structures are planned to take effect from 1 April 2026.

10. ARAC is asked to endorse this review as the primary effectiveness review for 2025/26. In addition to this, a simple questionnaire will be issued in Q3 asking each committee to reflect on what works well and what could be improved. It is also proposed that the term "effectiveness reviews" be replaced with "quality and governance reviews" to better reflect the focus on continuous improvement. The board will continue to receive the fuller survey as it did last year.

11. An further progress update will be provided to ARAC in December 2025, following further engagement with ELT, the ARAC sub-group and the NEDs group.

RECOMMENDATION

12. ARAC is asked to:

    (a) Note the update and progress
    (b) Agree that this current review of committee remits together with a simple questionnaire of all committees in Q3 constitutes the 2025/26 effectiveness reviews, now referred to as 'quality and governance reviews'.

KEY ISSUES/IMPLICATIONS
As set out above.

REPORT APPROVAL ROUTE
Concepts discussed: 16 July 2025 – Executive Leadership Team 25 July 2025 – ARAC sub-group

REPORT APPENDICES
N/a

REPORT CHECKLIST

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

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

AGENDA ITEM No	**10.1**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

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

MEETING	Audit, Risk and Assurance Committee
DATE	02 September 2025
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

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 has commenced an ambitious integrated governance programme aimed at enhancing governance structures from floor to board and which aims to streamline and unify the mechanics and dynamics of governance across the Trust.

3. There are no issues requiring escalation, though further assurance opportunities are scheduled for December 2025 and March 2026.

4. The programmes of work agreed for 2025/26 are:

   - Quarter 1: Develop a new board, committee, organisational governance front cover and SBAR template; develop writing and presentation guidance to accompany this; and develop a LMS365 or cameo PowerPoint on AAA preparation and the use of new front covers. This is complete and rolling out currently.
   - Quarter 2: Meeting etiquette guidance; house style minutes. This has commenced and is on track.
   - Quarter 3: Accountability, assurance and governance handbook. This has commenced and is on track, with an outline of the handbook included in this paper as foreshadowed in March 2025.
   - Quarter 4: AI for governance. Discussions have commenced with the digital team and some elements are included in the Q2 work.

RECOMMENDATION

5. Members are asked to:

(a) Receive assurance on progress of the programme and the 2025/26 deliverables and note the roll-out of the new report templates and writing guidance; and (b) Provide any feedback on the direction of travel and outline of the IGP handbook

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

REPORT APPROVAL ROUTE
N/A

REPORT APPENDICES
Annex 1: Integrated Governance Programme Deliverables Annex 2: Board and committee report writing guidance Annex 3: New template, short form front cover Annex 4: New template, SBARN

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

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

SITUATION

1. This paper updates the committee on the progress of the Integrated Governance Programme (IGP) following the initial paper in March 2025, which set out the shape of the framework, the development of standards for its operation and the plans for its implementation across the Trust.

2. The subsequent paper presented to the June 2025 meeting outlined the expected deliverables for the 2025/26 programme of work and identified the benefits and next steps which will be delivered over the next 2-3 years.

3. The paper before committee today provides an update against the deliverables within this year's work programme for assurance.

BACKGROUND

4. Board and committee governance has been significantly improved over the past 2-3 years as evidenced through positive Structured Assessments and a good programme of committee effectiveness reviews.

5. The Corporate Governance team has since turned its attention to enhancing governance structures at all levels from floor to board and replicating those principles of good governance, throughout the Trust, which have been developed and established for the board and its committees. This is the basis of the Integrated Governance Programme (IGP), which aims to streamline and unify the mechanics and dynamics of governance across the Trust.

6. A set of simplified governance principles that can be applied to the existing, maturing and emerging elements of the Trust's governance, accountability, risk and assurance frameworks is central to the programme. These will support openness and transparency, efficiency, and accountability at all levels from 'floor to board.'

7. The IGP began as a deliverable within the 2024/25 Integrated Medium Term Plan (IMTP), which was an enabler to establishing this programme of work, and several outputs have already been delivered. These are:

    - Mapping of governance structures floor to board as a single source of truth. This was presented to ARAC in March 2025 and can be accessed via the link to the Miro Board IGP. The map has been communicated to the organisation and is in use.

- Development of a legislative universe with a compliance prioritisation audit undertaken. This forms the basis for future work to support policy and audit.
- Digitised Corporate Governance Standard Operating Procedure. This is in use by the board and committee secretariat; however, the vision is to roll this out more widely throughout the Trust in a 'lite' version to support the embedding of these principals in all forums.

ASSESSMENT

8. While not a formal IMTP deliverable for 2025/26, there is significant work required to ensure that the underlying mechanics and dynamics of governance function in a cohesive and efficient manner.

9. Good progress has been made against the IGP work programme and against the 2025/26 deliverables which are highlighted throughout the report and contained in the CorGov Local Directorate Plan. The detail of the programme is captured in Annex 1.

Quarter 1 2025/26 Deliverables

10. The deliverables for Q1 have now been completed within the agreed timeframes and these were to:

- Develop a new board, committee and organisational governance front cover, and SBARN template – these are at Annex 1 and 2.
- Develop writing and presentation guidance to accompany this. – these are at Annex 3.
- Develop an LMS365 or cameo PowerPoint on AAA preparation and the use of the new front covers. This has been developed and will be available as part of the roll-out.

11. A consultation on the new front covers and writing guidance was issued across the organisation on the 23 June 2025 and was open until 11 July 2025.

12. The Siren Notice included the publication of the organisational Miro mapping and the Alert, Advise and Assurance (AAA) report writing guidance. All related documents and guidance are available on the Corporate Governance Siren sub-page, here.

13. The documents were widely consulted on during this period.

14. The direction of travel was discussed with the Non-Executive Directors on the 27 February 2025 and the Assistant Director's Leadership Team received the documents on the 04 August 2025 with the Executive Leadership Team formally endorsing these on 13 August 2025.

15. The new templates and guidance will be rolled out throughout August 2025 with an agreed transition period of seven months where both old and new templates will be accepted. A firm transition date has been set for the 01 April 2026.

Quarter 2 2025/26 Deliverables

16. The development of the meeting etiquette guidance and minutes house style is well underway and on track for delivery as planned. These documents will be presented to the December 2025 ARAC meeting with broader engagement with members prior to that.

    In line with the tiering principles presented to ARAC in the IGP paper from March 2025, the minutes guidance is intended to support the development of an AAA report for most tier 2 and 3 groups in place of traditional minutes, with the use of co-pilot where appropriate to assist in their production. There are some interdependencies concerning the retention of meeting recordings and transcripts that require further clarification, which may – depending upon timing - result in an updated versions of these documents later in the year.

Quarter 3 2025/26 Deliverables

17. Whilst a draft of the Integrated Governance Handbook is scheduled to be presented at the March 2026 meeting, the outline of it is included below for information and discussion. The handbook is intended to be a living document, evolving with organisational needs and external expectations:

Purpose and Context

The handbook is a new and essential resource for the Trust. It has been developed in response to the accountability framework within which we operate and is designed to support the organisation from floor to board in meeting its accountability responsibilities and strategic objectives. It brings together, for the first time, a comprehensive view of our governance, risk and assurance arrangements, and provides practical tools and guidance to strengthen governance capability across all levels.

Structure of the Handbook

1. Accountability Framework

- Outlines the roles and responsibilities of key external stakeholders, including Welsh Government, Cabinet Secretary for Health and Social Care, NHS Wales leadership, and Commissioners.

- Details internal accountabilities, including those of the Trust Board Chair, Chief Executive (as Accountable Officer), Director of Finance, SIRO, Caldicott Guardian, and others.
- Links strategic commitments from Delivering Excellence 2030 to operational delivery via the IMTP, local delivery plans and PADRs as set out in the QPMF.
- Covers legislative, contractual and regulatory responsibilities (e.g. HIW, Audit Wales, HSE, Charity Commission etc).

2. Governance Frameworks

- Explains the Trust's standing orders, standing financial instructions, and scheme of delegation.
- Includes committee terms of reference and the ways in which they operate.
- Emphasises the importance of communication, transparency, Nolan principles, and continuous improvement.
- Captures the 2024 integrated governance work and its role in delivering strategic objectives and operational effectiveness.

3. Risk and Assurance Frameworks

- Introduces the Board Assurance Framework (BAF) and assurance mapping as complementary tools.
- Describes how strategic risks are identified and how assurance is sourced, tested and coordinated.
- Highlights the importance of assurance in enabling the board and external partners to have confidence in the Trust's governance.

4. Supplementary Materials

- Corporate Governance Secretariat SOP (complete) and SOP-lite for organisational forums.
- Governance forum mapping and tiering principles (initial mapping and tiering complete).
- Revised writing templates and presentation guidance (complete and rolling out in August 2025).
- Meeting etiquette SOP, minutes and AAA guidance, AI for governance (due in Quarter 2 and 4).
- Guidance on roles (chair, secretary, member, observer).
- Templates, training and education resources, NED scrutiny toolkit, and legislative universe (some of which are well advanced and others to be planned further for 2026/27).

Quarter 4 2025/26 Deliverables

18. Work in the last quarter of 2025/26 is planned to see work on Artificial Intelligence (AI) for governance which will include the following expected outcomes:

- AI, managed within a secure platform at WAST, which will bring several 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 or Chat GPT) being rolled out more widely at WAST. Co-pilot is currently limited to a few and Chat GPT is not yet secure enough to use widely.

Next Steps

19. There will be engagement with members on the meeting etiquette guidance, minutes house style and the handbook as work progresses.

20. The supplementary materials will continue to be developed and rolled out as part of the IGP throughout 2025/26 and monitored by committee.

2026/27 Work Programme

21. Future work planned for the IGP in 2026/27 or sooner includes:

- Finalise tiering principles and implementation/communication plan
- Version control and rules of engagement for Miro
- Alignment of nomenclature of governance forums
- Sector benchmarking
- Terms of reference repository and alignment document
- Effectiveness (lite) for operational and other governance forums
- Roll-out board governance SOP (lite) for operational and other governance forums
- With the digital team, determine standardisation of meeting artifacts
- Education and training plan
- Simplified floor to board governance principles
- Further refinement and development of the legislative universe

RECOMMENDATION

22. Members are asked to:
    a) Receive assurance on progress of the programme and the 2025/26 deliverables and note the roll-out of the new report templates and writing guidance; and
    b) Provide any feedback on the direction of travel and outline of the IGP handbook.

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 and writing guidance developed ➢ Feedback on both received from NEDs ➢ Documents shared with the ADLT and ELT ➢ Implementation plan finalised and commenced ➢ Aim to start use of new templates by 13 August 2025
Quarter 2 Develop meeting etiquette guidance to include: - Scheduling and invitations - Professional conduct - Recording and Documentation - Chat and camera functions - Meeting management - Follow-up and documentation - Access (languages, subtitles)	➢ 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.	➢ Draft guidance developed ➢ Information Governance Steering Group reviewing the issues of retention of meeting recordings ➢ Minutes house style draft developed and being socialised for feedback ➢ High level feedback received from NEDs

Deliverable	Desired Outcomes	Progress
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 included in the paper for ARAC ➢ Engagement with key groups will commence ➢ Draft document to be presented at ARAC – March 2026
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 or Chap GPT) being rolled out more widely at WAST. Currently co-pilot is limited to a few and Chat GPT is not yet secure enough to use widely.	➢ Already in use for several forums ➢ 'Promptathons' taking place for use I minutes etc ➢ Outcomes to be incorporated into minutes and writing guidance

WRITING AND PRESENTING EFFECTIVE BOARD AND COMMITTEE PAPERS

Writing and Presenting Board and Committee Papers — Summary Guide

[This will be a separate document – to be finalised when full guidance agreed]

Know your audience

Board members (especially Non-Executive Directors (NEDs)) take a strategic, not operational view.

Reports must enable oversight, assurance, and decision-making — not detail operational delivery.

Be clear on purpose

What is the Board/Committee being asked to do? (Approval, Assurance, Discussion, Information, Noting)

Check the Cycle of Business or agenda for clarity.

Avoid using "For noting" where "For assurance" is appropriate. Please refer to section 2.2 of the full guidance document for detail on definitions and correct usage.

Use the correct template

Board and Committee Report Cover Sheet:

- Short-Form Report – the summary section serves as the full report.
- SBARN Report Cover Sheet + SBARN - where deeper analysis, risk, or decision is required.

Max 600 words for the Report Summary. Max 6 pages for SBARN. The 6 pages for the SBARN is in addition to the covering pages before it.

Structure your report

Report Summary must provide:

- Highlights — key achievements / progress. These do not require a separate risk assessment; they are escalations for scrutiny.
- Lowlights — areas for improvement / concerns.
- Red Flags — risks requiring further scrutiny.

Do not repeat full report in Report Summary.

Use clear, concise language. Avoid jargon.

If using AI tools in the drafting of the report be aware of its limitations and the WAST guidance on protecting personal, confidential and proprietary information. Please refer to section 2.4 of the full guidance document, for further details.

Submitting your paper

Papers must be issued at least 7 calendar days before the meeting (Standing Orders requirement).

Papers received late impact assurance — compliance is monitored and reported. Refer to section 3.1 of the full guidance document, for future detail.

Reports must be signed off by the relevant Director.

Presenting your paper

Not every paper needs a presentation:

- Presentation (potentially with slide deck): complex/multi-faceted issues.
- Positioning only: key points and "ask" highlighted.
- No formal presentation: members read paper in advance; invite questions.

Presentation tips:

- Define your aim — what do you want members to think/feel/do?
- Prioritise key messages — use visuals where these are helpful.
- Allow time for questions — speak clearly and concisely.

Final Tips

Ensure your report is strategically relevant, focused, and actionable.

Good papers = clear purpose + highlights/lowlights/red flags + well-structured recommendations.

Poor papers = too operational, overloaded with detail, unclear purpose.

WRITING AND PRESENTING EFFECTIVE BOARD AND COMMITTEE PAPERS

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WRITING AND PRESENTING EFFECTIVE BOARD AND COMMITTEE PAPERS

1. INTRODUCTION

Boards and Committees are responsible for ensuring that the Trust is well-governed, complies with its statutory obligations, and delivers on its strategic objectives. A core responsibility of the Board is to set and oversee the organisation's strategic direction.

Well-written, purpose-led reports are essential tools to help the Board and Committees fulfil this role. They provide:

- clear insights to support informed strategic decision-making and oversight,
- a balanced view of risks, opportunities, and performance,
- a robust official record for governance and audit purposes.

Board and Committee members, particularly Non-Executive Directors (NEDs), do not operate at an operational level. Their time is limited, and meetings are typically held bi-monthly or quarterly. Reports must therefore be concise, focused, and well-structured, enabling members to quickly absorb the key issues and avoid missing important points buried in lengthy or overly technical content.

The phrase "If I had more time, I would have written a shorter letter" reminds us that producing a clear and succinct report takes effort. This guide is designed to help you do just that: to write concise, purpose-driven papers that meet the needs of your audience and equip you to present them with maximum impact.

2. WRITING YOUR PAPER

2.1. Know your audience

When writing your board or committee paper, always keep your audience in mind.

The board and its committees include NEDs. They are appointed by Welsh Government, who bring independent oversight, external perspective, and constructive challenge to the organisation's leadership and decision-making. The board also includes the Chief Executive, Directors (some of whom are voting members), and Trade Union colleagues. Committees draw from a similar mix,

including NEDs, Directors, Trade Union representatives, and other subject matter experts.

Writing effective papers for the board, and especially for NEDs, who may not be closely involved in day-to-day operations and adopt a more strategic perspective, requires a distinct approach. It differs significantly from writing reports for internal management, and should emphasise:

- clarity of purpose and message,
- structured presentation of information, and
- a balanced view of both opportunities and risks.

NEDs particularly will expect to see:

- a clear delivery plan,
- answers to the 'so what?' i.e. how the subject will benefit patients, staff, or the public,
- confidence levels i.e. how sure are we that the plan is robust and achievable,
- realism - if outcomes or targets are not being met, when will they be delivered, and are the proposed timescales and actions credible?

They will not hesitate to challenge plans or timescales if they believe they are unachievable, unrealistic, or unlikely to deliver the intended outcomes.

Often the expectations from a paper or a presentation are clear when the agenda is commissioned or through annotations in the cycle of business. If in doubt, refer to these documents or seek clarification before drafting your paper.

When preparing a paper for Board or Committee consideration, it's essential to understand the appropriate forum for its discussion i.e. public or private session. The Board and its Committees aim to conduct business transparently, but certain matters require confidentiality. These include issues such as contract awards, disciplinary actions, legal advice, and any content involving identifiable individuals or sensitive commercial information. If the content of your paper would be exempt from disclosure under the Freedom of Information Act 2000 it is likely more appropriate for private session. The Trust's Governance Practice Note 002 provides further explanation on what should be treated as private business.

Writers should also consider whether the content might inhibit open discussion or prejudice the effective conduct of public affairs if aired publicly. Draft documents, early-stage strategic thinking, or sensitive advice from external bodies may fall into this category.

Authors are encouraged to consult early if unsure, and to be mindful that decisions made in private must still be reported transparently—either through the Governance Report or Committee Chair highlight reports, depending on the forum. For more information see the governance practice note here: 002.

2.2. Purpose

Writing with a clear purpose is critical to helping board and committee members, especially those with a strategic, non-operational perspective, exercise their oversight and assurance responsibilities effectively. Your paper should make it easy for them to understand what is being asked of them, and why it matters.

When preparing your paper, ask yourself:

- What is the intended outcome of this paper?
- If writing for a committee, are you clear on what is within its remit for this issue?
- What specific action, assurance, or insight are we asking the board or committee to take away?

Remember, board members, especially NEDs, rely heavily on papers to understand whether the organisation is on track to deliver its objectives, whether risks are being managed, and whether issues are being escalated appropriately. Writing with this audience in mind is crucial (see "Know your audience").

Board papers generally fall into two categories: active or passive, although some papers may include elements of both. Be explicit about what you are asking the board or committee to do.

<u>Active Recommendations</u>

Active recommendations require the board or committee to provide oversight, scrutiny, or approval. These papers help the board to fulfil its core role: setting

strategic direction, overseeing delivery, monitoring risk and performance, and providing public assurance. Whether an item is for approval, endorsement, or assurance depends on the group or committee's delegated responsibilities or remit, the Trust's Standing Orders. The purpose should be clear from the confirmed agenda and commissioning process. If unsure, please contact the Corporate Governance Team.

Common types of active recommendation:

For approval or endorsement

- These papers seek formal approval or endorsement of a course of action. This could include significant financial decisions, strategic initiatives, or policies approval under Standing Orders. Sometimes a committee will recommend endorsement ahead of board approval.

For assurance

- Most board and committee papers are for assurance. They enable the board or committee to satisfy itself - and ultimately the public - that key risks and objectives are being appropriately managed and that required standards are being met.

- Assurance reporting should:
  - Provide clear evidence of progress and delivery,
  - Highlight risks, gaps, or issues in delivery or governance,
  - Support challenge and escalation where necessary.

- Tip: Do not label a paper "for noting" if the board or committee is being asked to exercise its assurance role (for example, monitoring delivery of a key plan or reviewing a risk area within its remit). In these cases, the paper should be "for assurance."

For discussion

- Papers "for discussion" invite board and committee members to shape thinking, typically around a new strategy or plan, policy, or emerging issue. Be clear what input you are seeking and what the next steps will be.

Passive Recommendations

Passive recommendations are included to inform the board or committee but do not usually require discussion or decision. Many will appear in the consent section of the agenda.

Common types of passive recommendation:

For information

- These papers are provided purely to inform and will not be allocated meeting time unless a member requests it. They typically include follow-up items or background information.

For noting

- These papers can serve two purposes:
  - In active papers, it allows the board or committee to formally record a key point in the minutes, for example "noting the next steps" or "noting the current position with Welsh Government."
  - In passive papers, it records formal receipt of information without requiring discussion, for example routine updates or audit reports placed on the consent agenda.

- Tip: Be clear why you are using "for noting":
  - If the paper requires members to acknowledge something as part of the board's assurance role, it may be part of an active paper.
  - If the paper is purely background or transparency, it should go under consent agenda and be truly passive.

Final tip: check the agenda

The expectations of board and committee members are reflected in the agenda and in the cycle of business. If you are unsure whether your paper should be "for assurance", "for approval", or otherwise, check these documents or seek advice.

2.3. Using the Standard Templates for Board and Committee Reporting

To support clarity, consistency, and effective governance, all papers submitted to the Board and its Committees must use the standard reporting templates provided by the Board Secretariat. These templates help ensure that key information is clearly presented and that reports are structured to support the Board's and Committees' decision-making and assurance roles.

(a) Templates

There and three key templates to support consistent, high-quality reporting to the Board and its Committees. These templates should also be used when preparing papers for internal organisational governance forums.

The templates and guidance are available [here], and include:

- **Board and Committee Report Cover Sheet - Short-Form Report** [Template CG001- TO INSERT WHEN ON SIREN]: used where the Report Summary section serves as the entire report, for example, for straightforward or routine matters, approval of policies, or to provide context, purpose and the 'ask' of the board or committee for external documents or presentations.

- **Board and Committee Report Cover Sheet with SBARN** [Template CG002- TO INSERT WHEN ON SIREN]: used where the issue requires a full SBARN to provide deeper analysis, highlight significant risks, or support more substantial Board or Committee oversight and governance. The Report Summary on the Cover Sheet provides a concise overview, with the full SBARN and any attachments forming the main body of the report.

Under no circumstances should report writers remove any fields from the templates. All fields must be completed, even if marked not applicable.

(b) Key Governance Declarations on the Template

The template includes several key governance and assurance checks to support decision-making and demonstrate alignment and risk mitigation. This section must be completed for both short form and full SBARN cover sheets. The declarations include:

- Strategic objective(s) the report supports
- Risk(s) this report mitigates
- Health and Care Quality Standards this report supports
- WAST Wellbeing objectives this report supports
- Impact assessments for consideration

The template provides a checklist for these and helpful links to further information. It is anticipated that as you use this new template more regularly that the related objectives and standards will be clear.

There is also an approval/scrutiny route on the template. This provides assurance on other forums where this matter has been reviewed, in particular the internal operational and strategic arms.

(c) Length

When completing the Board and Committee Report Cover Sheet, whether as a Short-Form Report or as the SBARN Report Cover Sheet, aim to limit the content in the Report Summary section to no more than 600 words wherever possible. If the subject matter cannot be addressed clearly within this space, you should consider whether a full SBARN (up to a maximum of six pages) is required to supplement the Cover Sheet.

If you find that you cannot address the key issues within this length, revisit the purpose of your report to ensure you are not including material that is outside scope or unnecessary. Where additional detail is required and is material to the board's or committee's scrutiny or assurance role, it should be included as an appendix within the main report pack, not placed in the Reading Room.

To streamline meeting materials, a Reading Room has been established in iBabs (the digital board platform). This space is for supplementary material that members may choose to review, but which is not required for scrutiny, decision-making, or assurance. The core paper, whether a Short-Form Report or SBARN Report Cover Sheet with SBARN and annexes, must contain all information necessary for the board or committee to discharge its responsibilities.

Documents placed in the Reading Room will also be published as 'Supplementary Material' on the Trust's website, alongside board and committee papers.

(d) The Report Summary (formally known as the Executive Summary)

The Report Summary is a concise summary designed primarily for executives and other high-level decision-makers. It condenses the most important information - the highlights, lowlights, and red flags - into a brief, accessible overview.

The Report Summary should always serve as a clear and standalone snapshot of your report, enabling Board or Committee members to quickly understand the key issues, risks, and proposed actions. It is the primary touchpoint for busy attendees who may not read the full document in detail, particularly where an issue is technical or complex. A well-crafted Report Summary ensures that members can still grasp the overall position and governance implications at a glance.

The way you write the Report Summary depends on how you are using the Board and Committee Report Cover Sheet:

- When used with an SBARN Report Cover Sheet, the Report Summary provides a concise overview of the issues and assurance status drawn from the full SBARN. It must highlight the key points without duplicating the full content of the SBARN.

- When used as a Short-Form Report, the Report Summary is the entire report. It must contain all the information the Board or Committee needs to understand the issue and take any necessary action, without relying on a separate SBARN.

In all cases, prioritise clarity, relevance, and governance value. Your Report Summary is a vital tool in helping Board and Committee members focus on what matters most.

An effective Report Summary focuses on three key elements:

- Highlights
  - Key achievements or areas of strong performance. These reassure Board or Committee members that strategies or processes are working well and may showcase good practice.
  - *Examples*: delivery of a key milestone; improved performance against a target; successful risk mitigation.

- Lowlights
  - Underperformance or areas falling short of expectations. These signal where improvement is needed and promote accountability.
  - *Examples*: negative trends; failure to meet targets; amber-rated risks requiring attention.

- Red Flags
  - Urgent issues or emerging risks that require immediate attention to prevent significant negative outcomes.
  - *Examples*: critical service failures; serious quality or safety risks; escalating financial risks.

By clearly presenting these elements, the Report Summary enables members to understand the current position, risks, and proposed actions — even if they do not read the full report and annexes.

A Report Summary is not:

- A list of items covered in the report.
- A repeat of the report's full content or structure.
- A narrative history of the project or programme.
- A general commentary (it must focus on what the Board or Committee needs to know now).
- A place to introduce new information not covered in the main report.

(e) <u>The SBARN</u>

The SBARN format is used to structure reports where the Board or Committee needs to understand a situation clearly and assess the required actions or risks. It supports good governance by promoting structured assurance and enabling well-informed decision-making. Use the SBARN format when:

- The matter is complex, involves multiple layers of analysis, or presents significant implications or options.
- Key risks need to be clearly articulated and addressed.
- The Board or Committee must make a major decision, requiring full context and analysis.

- The issue carries substantial patient safety, service quality, or financial consequences.
- The organisation needs to demonstrate due diligence in how the issue is being addressed, particularly for matters of public concern.

The SBARN format was originally developed in the healthcare sector (adapted from the US Navy) and is now widely used across the NHS to structure clear, consistent communication in high-stakes situations. Its component parts are explained below:

Situation: Clearly state the primary issue or concern. This should answer:

- What is happening now?
- Why is it urgent or important?
- What decision or action is required from the Board/Committee?
- Be direct and specific — this allows the audience to quickly grasp the purpose of the paper.

Example: "In accordance with the Committee's Cycle of Business and Standing Orders, the annual Gifts and Hospitality Register is presented to the Audit, Risk and Assurance Committee (ARAC) each year in Q1 for review. The timing aligns with the closure of the previous financial year and ensures compliance our Standards of Business Conduct Policy and statutory transparency obligations."

Background: Provide brief context to help the reader understand the current situation. Include:

- What led to this situation?
- Relevant legislative, regulatory, or process requirements.
- Previous decisions, data, or events that are material.
- Avoid unnecessary history or detail - this section should remain clear and factual.

Example: "In line with the WAST Standards of Business Conduct Policy, all offers of gifts or hospitality must be recorded and reported annually to ARAC. This is to ensure compliance with legal requirements and to mitigate the risk of real or perceived conflicts of interest. The Register covers the period 1 April 2024 to 31 March 2025."

Assessment: Analyse the current situation and provide informed judgement:

- What is the current impact?
- What are the key risks or challenges?
- What opportunities or mitigating factors exist?
- What is the current level of assurance?

Use evidence and data to support your assessment. Focus on the 'so what', i.e. what does this mean for the Board or Committee?

Keep the length of papers manageable. As a guide, aim for no more than six pages of core content, with technical detail or statistics in appendices. Use structured layout and bullet points for clarity.

Where appropriate, include sources (hyperlinked if possible).

Recommendation: The recommendation should match what is on the Cover Sheet ensuring consistency and clarity. The template does in fact refer the reader back to the cover sheet so there is often no need to duplicate the recommendation.

Recommendations should:

- Clearly state the action you are asking the Board or Committee to take.
- Briefly explain why this is the preferred approach.

Example: "It is recommended that ARAC:

- *Receive assurance on the completeness and transparency of the Gifts and Hospitality Register for 2024–25.*
- *Endorse the planned actions to maintain awareness and compliance during 2025–26.*

By following the SBARN structure, you can ensure that your report is clear, logically organised, and actionable, providing the Board or Committee with the assurance, insight, and recommendations needed to fulfil their governance responsibilities.

Next Steps: Explain at a high-level what the next steps in relation to the activity are, where relevant to the committee or the board.

Adding **attachments** to SBARN or front cover:
It is often necessary to submit papers with supporting documents as either an 'appendix' or an 'annex'. The terms *annex* and *appendix* both refer to supporting material added to the end of a document, but they serve different functions.

An **appendix** includes information that directly supports or expands on the main content—such as clinical data, audit results, staff survey outcomes, or detailed policy explanations. This data is typically referenced within the main body of the report and helps provide deeper understanding of specific points.

An **annex**, by contrast, is used to attach related documents that are relevant but can stand alone—for example, a copy of an external report, a full version of a policy, or a separate procedural document. These are usually included at the back of a report to provide context or completeness, without being central to the main discussion. In short: appendices support the detail; annexes are attached as complete, standalone items.

2.4. Using Artificial Intelligence When Writing Your Report

AI tools (such as Co-Pilot others) can be helpful in improving clarity, flow, structure, and the quality of your writing, and their sensible use can be a real advantage in supporting your drafting.

However:

- AI tools must not be used to input, process, store, or generate content that contains personal data, confidential material, or any unpublished sensitive organisational information.

- Before using AI tools, you must read and follow the guidance in the WAST Siren Notice on AI and Information Governance. This sets out what is and is not appropriate use in line with our policies.

Tip: AI tools can help with how you say something, but not what you say. The quality, accuracy, and governance value of the content remains your responsibility.

2.5. Tone and pitch

Tone plays a crucial role in conveying the report's purpose. Is the intent to instil urgency, request approval, highlight serious concerns, or provide closure on resolved matters? For example, using overly positive language to describe a significant project delay with substantial financial repercussions may fail to reassure the board that the situation is under control. Instead, a balanced and realistic approach signals that the issues are understood and being managed responsibly.

It's equally important to consider the audience. In the case of the board/committee, this often includes the public and other stakeholders in open meetings. As a statutory organisation, we have a duty to present information clearly and transparently. Ensuring that the board and the public can easily understand the content helps build trust and demonstrates how the organisation is addressing its challenges and risks. Also bear in mind that all open papers for the board and its committees are made available to the public. Using plain English and clear language when drafting reports will improve wider accessibility.

2.6. Structure and accessibility

A well-structured report helps readers quickly locate the information they need, even if they are encountering the topic for the first time. By providing clear context and a logical flow, authors can ensure that key points stand out. The writing should be straightforward and concise, avoiding unnecessary complexity and jargon. If technical terms must be used, they should be fully explained so that everyone, regardless of their familiarity with the subject, can understand.

Accessibility also means presenting information in a format that is inclusive for all readers. This includes using legible font sizes, clear visuals, and formatting that adheres to accessibility standards. By making the report easy to navigate and ensuring the content is readable for everyone, authors can support equitable access to the information and enhance the paper's overall clarity and impact.

- Segoe UI 12pt font
- No embedded documents
- Single line spacing
- Paragraphs are numbered (in report and Report Summary)
- Page numbers
- Recommendation in the SBARN matches the front cover

- Left aligning the text / paragraphs
- Using the most recent / recently updated organisational templates

2.7. Style Guide

The way we write, format, and present our papers and reports serves as a reflection of our organisation's leadership. It's about conveying who we are, what we stand for, and the message we send to our patients, staff, and stakeholders. The quality and consistency of our written materials have a direct impact on how we're perceived and, ultimately, on our success as an organisation.

Every document we produce speaks to our professionalism and commitment to transparency. That's why it's a hallmark of good governance to maintain consistency and clarity in our writing practices. From the use of apostrophes to the application of capital letters, every detail contributes to making our communications accessible and understandable. Adhering to the standards in the WAST style guide [to be finalised] not only enhances our credibility but also ensures that our messages are clear, our audience is well-informed, and our organisation's image is strengthened.

2.8. Hallmarks of a high quality board paper

High quality Board and Committee papers share a number of key characteristics. These include the following which ensure they support effective governance, informed decision-making, and public accountability.

Clear purpose
The paper clearly states what the Board or Committee is being asked to do and why. It reflects their remit and strategic role.

Clarity of message
Key points and recommendations are easy to identify. The Report Summary provides a clear snapshot of highlights, lowlights, and red flags.

Concise and focused
The paper covers what the Board or Committee needs to know — no more, no less. It avoids unnecessary operational detail.

Assurance-led

The paper enables the Board or Committee to judge the level of assurance being provided, identify gaps, and highlight where further action or scrutiny is needed.

Actionable recommendations
The recommendations are clear, specific, and linked to the purpose of the paper. They set out exactly what is required from the Board or Committee.

Accurate and evidence-based
Statements and conclusions are supported by evidence. Data is accurate and relevant to the purpose of the paper.

Strategically aligned
The paper clearly links to the Trust's strategic objectives, the Wellbeing of Future Generations (Wales) Act, and any relevant national priorities.

Professional and well-structured
The paper is well written, logically structured, and professionally presented. It reflects the importance of the Board's public role and scrutiny.

3. SUBMITTING YOUR PAPER

3.1. Deadlines

Please stick to the deadline you have been provided, even though this may seem quite far in advance of the meeting. Under the Trust's Standing Orders, all Board and Committee papers must be issued at least seven calendar days before the meeting. This is a public accountability requirement, and we are frequently audited on our compliance with it. The deadline dates for the meetings of the Trust Board and Board Committees in any year are available here: Integrated Governance Programme.

To meet this statutory deadline, we need to receive papers in advance of the seven-day point to allow the corporate governance team to carry out essential checks. These include ensuring that the report is appropriate for a public meeting (e.g. does not contain commercially sensitive or personal information), that it aligns with the purpose for which it was commissioned, and that the content supports the Board's or Committee's assurance role.

Late or deferred reports disrupt work programmes and can create gaps in the Board or Committee gaining assurance. Such instances are highlighted to the Board or Committee. The corporate governance team also maintains a record of whether papers are submitted on time, and this is reported to directorate management meetings to promote ongoing improvement in compliance.

If you need more time to prepare your paper, please contact us as early as possible. Any decision to accept a late paper rests with the Board or Committee Chair, in line with Standing Orders, and a clear rationale will be required to support their consideration.

When Board and Committee dates are set at the beginning of each year, a supplementary document is circulated to provide advance notice of submission deadlines. This, alongside the Cycle of Business for each Committee, enables report writers to plan ahead and ensure that their reports follow the appropriate internal governance processes before submission to the corporate governance team.

3.2. Sign Off

Reports for the board and committees must be signed off by the relevant Director lead before submitting the report to the corporate governance team.

3.3. Feedback

Peer feedback helps improve the board paper, especially when seen from a fresh pair of eyes.

If this is your first time creating a board paper, please do ask for feedback. Many of the board members will have had previous experience with such papers and may be able to give you some pointers for your next one.

WRITING AND PRESENTING EFFECTIVE BOARD AND COMMITTEE PAPERS

4. PRESENTING YOUR PAPER

How you present your report at the meeting is an extension of how you have written it. The Board and Committees rely on clear, purposeful reports to support effective governance, and they expect verbal presentations to reinforce this. Your role is to draw out the key messages — highlights, lowlights, and red flags — and support members in discharging their assurance and decision-making responsibilities.

Not every paper requires a formal presentation — but all papers require some positioning by the author or Director to help the Board or Committee engage with the right issues.

Broadly, there are three scenarios:

- **Papers requiring a presentation**: Typically, complex items with multiple moving parts, strategic implications, or evolving risks. These may benefit from a visual slide deck to support understanding. They may also require updates since the paper was written (which should be clearly flagged and captured for the minutes).

- **Papers requiring positioning only**: These do not need a slide deck but do warrant a brief verbal introduction to frame the discussion. The author or Director should highlight the key purpose or "ask" and may draw attention to any areas of particular risk, assurance, or strategic importance.

- **Papers requiring no presentation**: These may be less complex and these cases, the author or Director should simply say: "Members will have reviewed the paper in advance. I don't intend to go through it in detail, but I am happy to take any questions or points of assurance." This is preferable to the over-used phrase "take the paper as read", which can create confusion or an unintended impression that the content is not open to challenge.

You will typically have no more than one-third of the allotted agenda time for your item to introduce key points. The remainder of the time is reserved for questions and discussion. If you believe you will need additional time, please inform the Corporate Governance Team in advance so the agenda can be adjusted accordingly.

WRITING AND PRESENTING EFFECTIVE BOARD AND COMMITTEE PAPERS

Please be mindful that exceeding your allocated time impacts the flow of the meeting and can lead to later items being shortened, which risks devaluing those discussions and the presenters' time, and limiting the Board's or Committee's ability to give them proper attention.

If you are unable to answer a question, it is perfectly acceptable to say so. The answer will be captured as an action and followed up outside the meeting.

If you are presenting a paper here are a few tips:

Prepare with intention

- Define the aim and purpose of your presentation: what do you want the audience to think, feel, or do afterwards?
- Consider the audience's perspective: what will they be most interested in? What concerns or questions might they raise?
- Anticipate key areas of interest or challenge and prepare your responses.
- Structure content logically so that ideas flow clearly and are easy to follow.

Present effectively

- Start with the end in mind, be clear about the purpose of your report, and the ask of the Board or Committee.
- Be upfront about the objectives of your presentation so the audience knows what to expect.
- If using slides, remember that they should enhance what you say, not repeat it:
  - Prioritise visuals over text where possible. Use diagrams, charts, and images to aid understanding.
  - Consider the most effective way to present complex ideas (e.g. analogies, simple visuals).
  - Do not read from slides. Prepare separate notes if needed.
- Speak clearly and concisely. Aim for a total presentation time of not more than a third of the time allocated for the item so there is time for discussion.
- Use dual coding where appropriate (combining words and visuals to aid understanding and retention).

WRITING AND PRESENTING EFFECTIVE BOARD AND COMMITTEE PAPERS

Engage the Board or Committee

- Draw out:
  - Highlights — progress or positive performance
  - Lowlights — concerns or areas needing improvement
  - Red flags — risks or issues requiring further scrutiny
- Present only the essential data or messages — avoid overwhelming the audience.
- Clearly introduce any new information or updates since the paper was circulated.
- Be explicit about any action or decision required.

Speak with confidence

- Use clear, concise language, avoiding jargon and technical terms where possible.
- Practice to become familiar with the flow of your presentation and key points.
- Know your material well enough that you are not having to think on the spot.
- Pause for emphasis and allow space for questions or reflection.
- Be comfortable with silence and do not feel pressured to fill every gap.

Practical preparation

- Ensure your Director is aware and has seen the presentation in advance.
- Practice out loud, refining your timing, flow, and transitions.
- Prepare your slides, script or notes, and tech setup in advance:
- Have all files open and ready, and close your emails or Teams messages and applications, if possible, to avoid sharing anything confidential when presenting your slides.
- Test screen sharing and other technical elements ahead of the meeting to avoid delays or disruptions.

Finish with clarity

- Summarise your key message in one or two sentences.
- Clearly state any next steps, actions required, or decisions needed.

Agenda Item No.

REPORT TITLE

MEETING

Name of meeting	
Date of meeting	
Public or Private	Choose item from below
If private - rationale	Choose item from below

REPORT SPONSOR

Executive sponsor	
Author(s) of report	

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 is filler text for the purpose of seeing what this template looks like.
2. This template is for use without an SBARN therefore use this report summary section to convey your message in no more than 600 words where possible.

3. Each paragraph must be numbered and in the font Segoe UI and in 12 pitch. It should have 12 point spacing between each paragraph.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The [insert forum] is requested to:

1. XX
2. XX
3. XX

ADDITIONAL PAPER(S)

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

The [insert forum] is requested to receive the following:

1. XX
2. XX
3. XX

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
Insert

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

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

Agenda Item No.

REPORT TITLE

MEETING

Name of meeting	
Date of meeting	
Public or Private	Choose item from below
If private - rationale	Choose item from below

REPORT SPONSOR

Executive sponsor	
Author(s) of report	

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 is filler text for the purpose of seeing what this template looks like. This section should not be more than **600 words** where possible.

2. When used with an SBARN Report Cover Sheet, the Executive Summary provides a concise overview of the issues and assurance status drawn from the full SBARN. It must highlight the key points without duplicating the full content of the SBARN.

3. Each paragraph must be numbered and in the font Segoe UI and in 12 pitch. It should have 12 point spacing between each paragraph.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The [insert forum] is requested to:

1. XX
2. XX
3. XX

ADDITIONAL PAPER(S)

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

The [insert forum] is requested to receive the following:

1. XX
2. XX
3. XX

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
Insert

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

SITUATION

1. XX

BACKGROUND

2. XX

ASSESSMENT

3. XX

RECOMMENDATION

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

NEXT STEPS

5. XX

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

AGENDA ITEM No	**10.2**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

MID-YEAR REVIEW OF OPERATING ARRANGEMENTS

MEETING	Audit, Risk and Assurance Committee
DATE	02 September 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. As part of the annual board and committee effectiveness reviews, a series of changes to board and committee operating arrangements were agreed for implementation throughout 2025/26.

2. These changes were noted by the Trust Board on the 29 May 2025 and have been incorporated into the Corporate Governance Directorate Plan for delivery and monitoring.

3. This report provides a bi-annual update to the Audit, Risk and Assurance Committee (ARAC) on the progress against the actions.

RECOMMENDATION:

4. **Members are asked to review and discuss the bi-annual update on agreed changes to operating arrangements for the board and committees for 2025/26 and take assurance from the update provided on the progress against the actions.**

KEY ISSUES/IMPLICATIONS

Not applicable.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES
Annex 1: Mid-year review of operating arrangements.

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

Item 10.2 Annex 1

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
Section 1: Board and all committees	1.1 Further consideration to holding board meetings at venues other than Cardiff in 2025/26.	Work has begun on this consideration, and it is intended that it will be brought to the ARAC in December 2025.	01 January 2026	
	1.2 Introduce progress reports on 'what good looks like' for the strategic objective within committee remits will support the call for more of a strategic focus.	This is an action that sits outside of CorGov and is being advanced by the Strategy, Planning and Performance Directorate.	30 October 2025 – *check in date*	
	1.3 Revised approach to minutes for the Trust Board and its committees.	Draft developed and being consulted on. Q2 deliverable	30 September 2025	
	1.4 Updated board skills matrix for board members, which is aligned to the board committees.	The updated skills mix questionnaire will be shared with the board by the end of August 2025.	30 September 2025	
	1.5 Where possible in 2025/26 the introduction of more hybrid meetings.	This is happening for all committees where it is considered appropriate / welcomed by the respective Chair.	n/a	

Item 10.2 Annex 1

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	1.6 A reduction in the reporting against the audit tracker will be considered by ARAC in an attempt to reduce volume for committees and increase assurance.	This is a Q4 deliverable on our CorGov Directorate Plan and is in progress.	Q4 2025/26	
	1.7 New report front covers and SBAR templates. This includes a short form report which includes a requirement to set out purpose of report and alignment to strategic objectives, wellbeing objectives and health and care quality standards. This will support the desire to use more presentations over SBAR where appropriate.	The new templates and report writing guidance was published w/c 12 August 2025	n/a	
	1.8 Writing guidance will set out the purpose of the executive summaries in an attempt to ensure they are reflective of the comments received by members of the board and the committees of the board.	The new templates and report writing guidance was published w/c 12 August 2025	n/a	

Item 10.2 Annex 1

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	1.9 Presentation guidance and support will be provided to colleagues in the Trust.	The new templates and report writing guidance was published w/c 12 August 2025	n/a	
	1.10 Feedback following meetings on reports – both positive and where there are areas of improvement – are encouraged from committee members. This will ensure that we are working towards a continuous improvement in paper length and assurance.	No formal action required. Feedback is being given in meetings regarding report quality and the assurances that this affords.	n/a	
	1.11 A 'reading room' will be established in iBabs for documents that members may wish to review for further information, but which are not vital for scrutiny and oversight.	Completed; in use for all board committees and the board via iBabs.	n/a	
	1.12 Members encouraged to pose questions to report writers before meetings and allowing more time for questioning during sessions were suggested to enhance engagement.	No formal action required.	n/a	

Item 10.2 Annex 1

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	1.13 Continue with agenda setting meetings and encourage themes for meetings to aid in the flow and triangulation. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. Likewise, presenters should ensure they are cognisant of the time allocated which includes time to present and for discussion.	No formal action required as the agenda setting meetings are continuing throughout 2025/26.	n/a	
Section 2: Academic Partnership Committee	2.1 Consideration for greater use of presentations within meetings to reduce the number of papers received. This was specifically in reference to Academic Partnership Committee but will be considered for all committees.	No formal action required. Noted that where presentations are in use, cover papers are requested to make it clear to the audience what it has been received for, to aid discussion.	n/a	
Section 3: Audit, Risk and Assurance Committee	3.1 The Corporate Governance Team will ensure that ARAC is aware of the discussion on internal audit reports from	This is business as usual.	n/a	

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	committees if they review them ahead of ARAC, and vice versa when they come to ARAC first.			
	3.2 Trending on risk scores will be added to the risk management report.	This is business as usual from Q2 2025/26.	n/a	
	3.3 A paper setting out a more focused understanding of where the three lines of defence sit within the organisation and their importance will be cycled into the work programme.	This will be brought to ARAC in quarter three in December 2025 with the Governance and Accountability handbook. The outline of the handbook is before ARAC at this meeting.	30 October 2025	
	3.4 The committee induction programme for ARAC and other committees with be rolled out as new members join.	The committee induction for each committee is being delivered as required / when new members join respective committees.	n/a	
Section 4: Charity Committee	4.1 A further development session to be considered for the Corporate Trustee in 2025/26 on trustee responsibilities.	This has been programmed for the board development day in February 2026.	28 February 2026	

Item 10.2 Annex 1

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	4.2 Lived experience to demonstrate on new proforma the charitable impacts beyond staff benefits.	This is business as usual.	n/a	
	4.3 Committee to maintain a strong focus on equality, diversity and inclusion in its strategic direction.	No formal action required. Equality, diversity and inclusion matters considered within the charity's operations as business as usual.	n/a	
Section 5: Finance and Performance Committee	5.1 A board development session on the use of the MIQPR will be held on 24 April 2025, and the annual review of all MIQPR metrics will come through committees in May.	Complete	Complete	
	5.2 A new finance dashboard is in development and will be considered by the committee in 2025/26.	WAST (and other NHS Wales orgs) are dependent on a national dashboard being developed as part of the NHS Wales finance system refresh (Oracle Financials). If no national solution is produced by end of Dec 25, then WAST will tailor an internal bespoke solution commencing in	March 2026 – *Check in for December 2025*	

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
		Quarter 4 of the 2025/26 Financial year in readiness for rollout from Quarter 1 of the 2026/27 financial year.		
Section 6: WASPT	6.1 Continue with agenda setting meetings with the co-chairs and encourage themes for meetings to aid in the flow and triangulation as well as timing of individual items. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. This will ensure there is sufficient time for solution focused discussions and airing of issues.	No formal action required. This is business as usual.	n/a	
	6.2 The terms of reference provide that papers are available seven days before the meeting, however this does not always align with the Trade Union	This is business as usual, and the Corporate Governance Team work closely with Trade Union Partners (TUPs) to align publication of papers with TUP	n/a	

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	Partners pre-meeting timetable. Best endeavours are made to ensure papers are available for that pre-meet and likewise Trade Union Partners will endeavour to timetable that meeting within the seven days to allow for a full pack to be available.	pre-meets to allow TUP time to review the papers and raise any issues ahead of the meeting.		
	6.3 Partnership working will continue in 2025/26 to ensure that there is continuous effort to maintain trust and openness, the details of which will be discussed in the group.	No formal action required.	n/a	
	6.4 The sessions on how to run effective meetings and on financial reporting will be carried over into 2025/26.	*Financial reporting:* Finance colleagues will deliver this session, and it is intended for Q3 2025/26. Arrangements will be progressed from September.	20 December 2025	

Item 10.2 Annex 1

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	6.5 The sessions on how to run effective meetings and on financial reporting will be carried over into 2025/26.	*Effective meetings:* The delivery of this action is aligned to the meeting practice and participation guidance coming out in Q2 2025/26.	30 September 2025	
	6.6 There are opportunities to learn more about legislative changes, as well as policy issues through workshops post WASPT meetings, as well as taking advantage of employment-related sessions with the People Services Team which will be explored in 2025.	No formal action required.	n/a	

Item 10.2 Annex 1

Colour	Meaning	Typical Action
Blue	Completed	No further action needed
Green	On track	Continue as planned
Amber	Minor issues	Monitor closely, possibly mitigate
Red	Major issues	Escalate and intervene urgently

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

AGENDA ITEM No	**11**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**7**

AUDIT TRACKER 2.0 – JUNE 2025 (2025/26 Q1)

MEETING	Audit, Risk and Assurance Committee
DATE	4 September 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Lisa Trounce, Head of Compliance and Assurance
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Audit, Risk and Assurance Committee (ARAC) with the current position with respect to management actions for audits within the purview of the Committee, in addition to the wider progress in quarter.

2. **Progress Against Internal Audit Actions:** There continues to be good engagement with Directorates on the Tracker 2.0. At the start of Quarter 1 there were 88 internal audit actions open. Updates and evidence received resulted in 20 actions (23%) of the total number of actions being closed during the quarter – this illustrates a reduction in closure rate compared to Quarter 4, when 51% were closed. Despite this reduction, performance improved in terms of closing actions on time, and work continues across directorates to manage the remaining open actions, most of which are due in the coming quarters.

3. **Closure Rate - Forward Trajectory:** Although fewer actions were closed in Quarter 1, 70% were closed by their original deadline, an increase from 26% in Quarter 4 - this suggests progress having been made in setting more realistic and achievable completion dates at the point of audit reporting. Of the remaining 68 open audit actions, 77% (52 actions) are scheduled for closure in Quarters 2 and 3 (July to December 2025).

4. **Deadline Management:** Revised deadlines were applied to a total of 36 audit actions in Quarter 1 (19 internal audit actions, and 17 external audit actions). The 19 internal audit actions with new revised dates equates to 22%, consistent with Quarter 4 and a continuation of the gradual improvement from previous quarters (29% in Quarter 2, and 28% in Quarter 3).

5. **ARAC Oversight:** A total of eight internal audit actions fell under the purview of ARAC in Quarter 1. One action (Risk Appetite Statement) was due for closure in July 2025 (Quarter 2) following a planned Board Development Session and Strategic Transformation Board review. The remaining seven actions originate from the 2024/25 Follow Up Internal Audit, covering areas such as:

   - Estates Condition
   - Disciplinary Case Management
   - Trade Union Release Time
   - Records Management
   - Seatbelt Action Plan (now closed)

   Most of these actions are progressing with plans or revised deadlines in place; some completion dates are still to be confirmed.

6. **Progress Against External Audit Actions:** At the start of Quarter 1 there were 51 open external audit actions. 22 were due for closure, of these 10 (45%) were successfully closed – a reduction from the 85% closure rate in Quarter 4, but an improvement on Quarter 2 (28%) and Quarter 3 (29%). Of the 32 actions from the Welsh Risk Pool Concerns Assessment 2024, 17 had revised dates applied in Quarter 1 to spread the workload more evenly through the year and make it more manageable. All three external audit actions under ARAC's purview (from the Audit Wales Structured Assessment 2024) were closed in quarter, leaving no open external actions under ARAC's purview at present.

7. **Audit Tracker Development:** Work is ongoing to develop **Tracker 3.0**, hosted on SharePoint, with testing underway, followed by training and implementation in Quarter 2. This version will support enhanced reporting, including **Power BI dashboards** tailored for different audiences.

RECOMMENDATION

8. The Committee is asked to:

   (a) Note the significant progress made in closing audit actions by their first date during 2025/26 Quarter 1;

   (b) Note the 12 internal audit actions for which final revised dates have been applied in quarter, and **invite** updates from the Directors responsible for these audits.

   (c) Note the first revised dates applied to 17 of the 32 external audit actions related to the WRP Concerns Assessment 2024.

(d) Receive assurance that the management actions for the audits within the purview of this Committee (at Annexes 2a- 2c in the reading room), and overall (at Annexes 1a-1d in the reading room), are being effectively and appropriately managed, closed off in quarter or clarity provided on dates which have moved and rationale.

KEY ISSUES/IMPLICATIONS
As set out above.

REPORT APPROVAL ROUTE
2025/26 Q1 Audit Tracker updates presented to the Assistant Directors Leadership Team: shared via email on 100725 and in the meeting held on 040825.

REPORT APPENDICIES

Tracker 2.0 25-26 Q1 (April - June 2025) – ARAC 040925 [in reading room]

- **Annex 1 – Full Audit Tracker (with actions shared in private session removed):**
  1a) Audit Tracker 2.0 – 25-26 Q1 Internal Audit Actions (Up to 2023/24) – Full Tracker
  1b) Audit Tracker 2.0 – 25-26 Q1 Internal Audit Actions (2024/25) – Full Tracker
  1c) Audit Tracker 2.0 – 25-26 Q1 External Audit Actions (2023/24) – Full Tracker
  1d) Audit Tracker 2.0 – 25-26 Q1 External Audit Actions (2024/25) – Full Tracker

- **Annex 2 – Filtered to show ARAC Audit Recommendations only:**
  2a) Audit Tracker 2.0 – 25-26 Q1 Internal Audit Actions (Up to 2023/24) – ARAC only
  2b) Audit Tracker 2.0 – 25-26 Q1 Internal Audit Actions (2024/25) – ARAC only
  2c) Audit Tracker 2.0 – 25-26 Q1 External Audit Actions (2024/25) – ARAC only

REPORT CHECKLIST

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

SITUATION

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

   Annex 1 – Full Audit Tracker (with actions shared in private session removed)
   Annex 2 – Filtered to the actions assigned to this Committee

BACKGROUND

2. In September 2023, the Audit Committee approved the Audit Process and Reporting Handbook which was subsequently revised to incorporate content from Audit Wales.

3. The Handbook includes roles and responsibilities of key stakeholders including:

   - **Directorate Points of Contact:** Points contact are responsible for progressing audit actions for their respective directorate with the Director and Assistant Directors/Deputies, ensuring that audit actions are included on the monthly directorate meetings, recording updates on the tracker, and escalating concerns where appropriate.

   - **Assistant Directors Leadership Team (ADLT):** The ADLT functions as the forum for approving the closure of audit actions, undertaking a 'check and challenge' role.

   - **Board Committees:** Committees are responsible for receiving relevant audit reports and monitoring progress of associated management actions to address audit recommendations.

   - **Audit, Risk and Assurance Committee (ARAC):** The ARAC scrutinises the progress of audits recommendations overall and escalates to the Board any issues or concerns.

4. Board committees (Quality, Patient Experience and Safety Committee; Finance and Performance Committee; and the People and Culture Committee) have each recently reviewed updates against audit actions under their purview.

5. These reviews are noted in the Committees' Assurance, Advice and Alert (AAA) reports to Board. No issues have been escalated to the Board to date.

ASSESSMENT

Internal Audit: - Full Tracker Review (Annex 1)

6. A high level of engagement with directorates on Tracker 2.0 updates for 2025/26 Quarter 1 was maintained. As a result, of the total of 88 open internal audit actions on the Tracker at the start of Quarter 1, 20 have been closed in quarter, representing 23% - a reduction from the 51% reported in Quarter 4.

7. Whilst the percentage of total internal audit actions closed in quarter is significantly less than in Quarter 4, of the 88 open internal audit actions, 31 were due in quarter. Of these 31 due actions, 13 (42%) were reported as completed, plus a further four actions which were not due until August 2025 but completed earlier than expected.

8. The table below provides a breakdown of the number of audit action closed in quarter, and whether they achieved their original agreed deadline or were closed after one or more revised date.

Year	No. Actions Closed in Quarter (Q1)	Date Completed			
		Original Deadline	1st Revised Date	2nd Revised Date	3rd Revised Date
2022/23	0	0	0	0	0
2023/24	3	3	0	0	0
2024/25	17	11	6	0	0
Totals	**20**	**14**	**6**	**0**	**0**
% of Total Closed in Quarter		**70%**	**30%**	**0%**	**0%**

9. The three 2023/24 audit actions closed in quarter were originally due for completion in the previous quarter (Quarter 4), and had first revised dates applied, so were not expected to be completed until Quarter 2. It is encouraging to note that these were completed shortly after the original deadline and before the first revised date.

10. Of the 11 2024/25 audit actions closed in quarter by their original deadline, four had already been completed at the time of audit reporting.

11. There are a further four audit actions relating to the 2024/25 Follow Up Internal Audit for which deadlines are yet to be agreed.

12. The figures for Quarter 1 are comparatively lower than those reported in Quarter 4, relative performance of audit actions being completed by their original deadline has increased significantly from 36% in Quarter 4, to 70% in Quarter 1; with the remaining six actions closed in quarter (30%) being completed by their first revised date. This is extremely positive and indicates greater improved accuracy in setting realistic deadlines within initial management responses.

13. As shown in the table below, the majority of the remaining open internal audit actions (i.e. 52 of the remaining 68, which equates to 77%) are planned for closure during Quarters 2 and 3 (between July and December 2025); with 11 (16%) not due until 2026/27, and completion dates to be agreed for the remaining five.

Year	Total No. of Remaining Open Actions (Q4)	Due for Closure During FY & Quarter				
		2025/26			2026/27	Date TBA
		Q2	Q3	Q4	Q1	
2022/23	3	2	0	0	0	0
2023/24	12	6	2	0	4	0
2024/25	53	24	18	0	7	5
Totals	**68**	**32**	**20**	**0**	**11**	**5**
% of Total Open Actions		**47%**	**30%**	**0%**	**16%**	**7%**

14. Of the 88 open internal audit actions updated during Quarter 1, 19 have been given **revised dates in quarter** (one to be advised); which equates to 22% of the total, compared to previous quarters: 22% in Quarter 4, 28% in Quarter 3, and 29% in Quarter 2 - showing a gradual and sustained downwards trend.

Quarter	24/25 Q2	24/25 Q3	24/25 Q4	25/26 Q1
% Open Actions with New Revised Dates Applied in Quarter	29%	28%	22%	22%

15. There are 12 open internal audit actions which have been assigned **final revised dates** this quarter:

Year	Audit Action Ref.	Internal Audit Title	Directorate	Original Deadline	Revised / Final Deadline
2022/23	621b	Technical Resilience	(Reported in Closed meeting)		
2023/24	635	111 Commissioning Final Advisory Report	Strategy, Planning & Performance	Apr-24	Dec-25
2023/24	681	Electronic Patient Care Records (ePCR) Clinical Compliance	Digital	Sep-24	Apr-26
2023/24	683			Sep-24	Apr-26
2023/24	684			Dec-24	Apr-26
2023/24	686			Sep-24	Apr-26
2023/24	701	Clinical Audit	Clinical	Mar-25	Sep-25
2024/25	003-24/25	Data Quality	Digital	Dec-24	Oct-25
2024/25	014-24/25	Resourcing Policy	Operations	Nov-24	Mar-26
2024/25	035-24/25	Exposure to Fumes	Quality & Nursing	Mar-25	Nov-25
2024/25	038-24/25			Jan-25	Sep-25
2024/25	040-24/25			Mar-25	Dec-25

16. The Directors response for the above actions (with the exception of ePCR which was discussed at the meeting of this committee in June 2025) have been asked to appear at this committee to discuss audit actions for which final revised dates were applied during Quarter 1:

16.1 The **2022/23 audit action 621b** is reported in the Closed meeting of this committee.

16.2 **Audit action 635 from the 2023/24 111 Commissioning Final Advisory Report** is dependent on the development of a new National Collaboration Agreement which is owned by the Joint Commissioning Committee (JCC), and is therefore outside of the control of the Trust.

16.3 As reported in Quarter 4, as the remaining actions from the **2023/24 Electronic Patient Care Record (ePCR) Internal Audit** are related to ICT, these were transferred from the Clinical Directorate to the Digital Directorate in March 2025, and revised dates have been agreed with Internal Audit colleagues.

16.4 **Audit action 701 from the 2023/24 internal audit on Clinical Audit** relates to the inclusion of clinical audit within organisational documents. The first meeting on the Clinical Plan has taken place with the inclusion of the clinical audit discussed. The new Head of Clinical Intelligence and Assurance attended the Clinical Strategy Workshops held in July 2025 to build on this section. The action was originally due for completion by the end of March 2025, and in Quarter 1 a second revised date of September 2025 was applied.

16.5 The **Data Quality audit action 003-24/25** relates to the digital literacy of staff and was originally due for completion by December 2024. As part of the refreshed Digital Plan, a full programme for assessing and improving digital literacy was planned for 2025/26. The Data Quality (DQ) team have reviewed DQ-related training freely available to WAST, and none were found to be suitable. Instead, the team will develop some awareness materials, collaborating with the Education team, this will predominantly feature a process flow map, highlighting areas where data quality plays a crucial role in WAST services. A second revised date of October 2025 was applied to afford sufficient time for full deployment.

16.6 **Audit action 014-24/25 from the Resourcing Policy internal audit** relates to completion of a mapping exercise to ensure that all local arrangements or differences in application of the policy are appropriately recorded. This action was originally due for completion by November 2024. However, as work on the

e-Timesheets remains ongoing, a second revised date of March 2026 has been applied.

16.7 There are three outstanding **audit actions (035-24/25, 038-24/25 and 40-24/25) from the 2024/25 Exposure to Fumes internal audit** - these were all originally due for completion during Quarter 4 (January – March 2025). Two of these open actions are dependent upon the uploading of resources to LMS 365 and the availability of training via LMS 365, with the third action regarding automatic transfer of information to the Data Vault reliant upon the capacity of the Digital Team to undertake this work. Second revised dates have been applied to all three of these actions: November 2025, September 2025, and December 2025 respectively.

17. The remaining open action from the Technical Resilience audit will be received in the closed session.

Internal Audit: – ARAC Actions (Annexes 2a-c in reading room)

18. In Quarter 1, there were a total of eight internal audit actions which fell under the purview of this committee:

18.1 One action was from the 2023/23 Risk Management internal audit relating to development of formal Risk Appetite Statements (RAs) and was originally due for closure in June 2024. At the end of Quarter 1, it was on its second revised date of July 2025, notwithstanding the sessions held with the Board to develop the RAs during this time and the progress made on this work. The Strategic Transformation Board considered all six RAs at its meeting on 11 August 2025. These are before the ARAC today and will be shared with the Board at the Development Session on 19 September 2025. The Board will be asked to agree and set the appetite against each of the Trust's six strategic objectives. At this point, the recommendation will be closed.

18.2 The other seven actions are all from the 2024/25 Follow Up Review internal audit and relate to outstanding actions in respect of previous audits:

a) Estates Condition: 1 action – due by March 2026
The Trust was looking to review its estate to assess condition and re-evaluate the assigned risk in the coming year. A 6-facet Survey Group established and specification under review. By early September 2025 a preferred surveying practice will be appointed to commence the surveys in the Autumn, to be completed by the end of the financial year. **Action remains open.**

b) Disciplinary Case Management: 1 action – due by September 2025
Whilst the audit schedule for monitoring compliance with the checklist is in place, there remained areas of non-compliance across case files being reported. Audit checklists continue to be conducted, the most recent taking place in March 2025. Following this, a training and awareness session was delivered to the People Services Team, emphasising the importance of maintaining accurate and up-to-date information in alignment with KPIs and professional standards. A deadline of September 2025 was applied to allow for a meaningful evaluation of progress, including retrospective assessment of trends and overall compliance. **Action remains open.**

c) Seatbelt Action Plan*:* 1 action – Already completed at time of reporting
The Assistant Directors Leadership Team (ADLT was to oversee the monitoring and compliance of the two outstanding actions within the Health and Safety investigation into the road traffic collision (RTC); and provide assurance to the Executive Leadership Team (ELT) via the AAA reporting mechanism. The two remaining recommendations have been incorporated into routine business practices and ADLT approved the closure of these actions, noting that all outstanding actions had now been completed. **Action Closed in Quarter.**

d) Trade Union Release Time: 1 action – completion date to be advised
Regarding the wider recommendation to revisit the Facilities Agreement, the Trust does not intend to do this as the Agreement is working for the organisation. Internal Audit noted that work was ongoing to develop an electronic timesheet which may be the long-term solution, and that quarterly reports were being produced but not formally reported and monitored with the Trust. Deadline to be advised. **Action remains open.**

***e) Records Management*:** 3 actions – completion dates to be advised
These three recommendations related to ongoing actions regarding: automation and incorporation of complex case data into the Information Governance Steering Group (IGSG) KPI report to enable trend analysis, and the plan for disposal of records (both physical and digital). Deadlines to be advised. **Action remains open.**

External Audit: - Full Tracker Review (Annexes 1a-1d in reading room)

19. At the beginning of Quarter 1, there were a total of 51 open external audit actions relating to the following:

20.

Audit Year	Audit Title	No. of Recommendations
2023/24	Audit Wales: Review of Costing Savings Arrangements	2
2023/24	Audit Wales: Quality Governance Follow Up Review	12
2024/25	Audit Wales: Structured Assessment 2024	3
2024/25	Welsh Risk Pool: Concerns Assessment 2024	32
2024/25	Audit Wales: Unscheduled Emergency Care (UEC) Arrangements for Management Demand – WAST	2

21. Of the 51 open external audit actions at the start of Quarter 1, 22 (43%) were due for closure. Following verification of evidence, a total of 10 (45%) of the due actions were confirmed as completed and closed in quarter – this is a significant decrease compared to the 85% reported as closed in Q4, but remains an improvement on the 29% reported in Quarter 3, and 28% in Quarter 2.

22. The two open audit actions related to the **Review of Cost Saving Arrangements** audit were both within their original date, with action 151 closed in quarter, and action 152 due for completion by August 2025 (Quarter 2).

23. Audit recommendations from the **2023/24 Quality Governance Review Follow-Up Audit (October 2024)** were reviewed by the Quality, Patient Experience and Safety Committee in March 2025. A total of 12 recommendations were subsequently added to the Audit Tracker, with completion dates ranging from June 2025 to March 2026. The single audit action that was due in June 2025 was confirmed as completed and closed in quarter, along with three other actions (all relating to Mortality Reviews) which were not due until December 2025 (2025/26 Quarter 3) but completed early.

24. A total of 32 new recommendations from the **Welsh Risk Pool (WRP) Concerns Assessment 2024** were also added to the Audit Tracker to be updated in 2025/26 Quarter 1. Of these, the two that were closed in quarter were identified as already completed at the time of Internal Audit reporting. Four actions are reported as being dependent upon Digital priorities / automated extraction work.

25. All 17 actions WRP Concerns Assessment actions that were due for closure during Quarter 1 have had first revised dates applied to ensure that the workload is spread more evenly over the coming year, making it more manageable:

	Already Complete (Closed Q1)	Required Completion Dates			Dates TBC (Depending on Digital)
		25/26 Q2	25/26 Q3	25/26 Q4	
No. Open WRP Actions	2	9	9	8	4

External Audit: – ARAC Actions

26. At the start of Quarter 1, there were three external audit actions in the purview for this committee – all relating to the 2024/25 Audit Wales Structured Assessment 2024, and these have all been closed in quarter. Therefore, there are currently no open external audit actions in the purview of this committee.

Management and Development of the Tracker

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

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

29. The current version of the tracker is now open for Directorate review for actions due between July and September 2025. These 2025/26 Quarter 2 updates will be presented to this Committee in December 2025.

30. The Corporate Governance Team continues to work on the development of the SharePoint solution for **Audit Tracker 3.0**. Testing is underway with internal stakeholder engagement, demonstration/training and system implementation by the end of Quarter 2.

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

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

(a) *Number of substantial/reasonable/limited/no assurance/advisory audit reports per year.*
Gives a general overview throughout the year and over audit years

(b) *Number of audit reports per committee oversight*
Gives a general overview of the spread of oversight of audit reports and those who may not be monitoring any reports

(c) *Number of high rated recommendations with actions more than 3 months past their original date*
High rated actions should be closed off as soon as practicable due to their risk profile. This will allow for escalations.

(d) *Number of actions for limited assurance audit reports more than 3 months past their original date*
Due to the issues that will arise in a limited assurance report they should be closed off asap and before follow-up reviews. This will allow for escalations.

(e) *Number of actions that have 'met' and 'not met' the original due date*
Gives an indication of the realistic nature of the original dates leading to a change in behaviour
Provides oversight of progress over audit years.
This may be similar as the table at paragraph 6 above.

(f) *Number of individual actions that have 'not met' revised dates*
Will indicate a potential issue in meeting an action or lack of progress for some other reason. Will need to be sure this is not a double count with some of the other metrics.

RECOMMENDATION

33. The Committee is asked to:

(e) Note the significant progress made in closing audit actions during 2025/26 Quarter 1;

(f) Note the 12 internal audit actions for which final revised dates have been applied in quarter, and **invite** updates from the Directors responsible for these audits.

(g) Note the first revised dates applied to 17 of the 32 external audit actions related to the WRP Concerns Assessment 2024.

(h) Receive assurance that the management actions for the audits within the purview of this Committee (at Annexes 2a- 2c in the reading room), and overall (at Annexes 1a-1d in the reading room), are being effectively and appropriately managed, closed in quarter or clarity provided on dates which have moved and rationale provided.

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

AGENDA ITEM No	**12**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**N/A**

TRUST POLICY REPORT

MEETING	Audit, Risk and Assurance Committee (ARAC)
DATE	2 September 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Lisa Trounce, Head of Compliance and Assurance / Policy Group Chair
CONTACT	Lisa.Trounce@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide a six-monthly update to the Committee on the status of the Trust's policy work programme, specifically the ongoing efforts to ensure key Trust-owned policies are up to date and compliant with review schedules.

2. The 2025/26 policy work programme was endorsed by this Committee in March 2025 with a total of 62 Trust-owned policies included in that programmed, categorised from high to low priority. These comprised of policies for which reviews were overdue, as well as in-date policies scheduled for routine review during the year.

3. A review of the programme was undertaken in May 2025. Following consideration of the identified risks and the capacity across relevant teams, seven policies were deferred to 2026/27. This adjustment reduces the total number of Trust-owned policies scheduled for review in 2025/26 to 55. The seven deferrals have been approved by the Executive Leadership Team based on rationales of team capacity, priority status of the policies deferred and other interdependencies affecting the timelines. Those deferred are:

    - Information Sharing Policy [New]
    - Information Governance Policy
    - Information Classification Policy
    - Confidentiality and Code of Conduct Policy
    - Access Control Policy
    - Trust Mobile Phone Policy
    - Quality Assurance Framework for Clinical Desk Policy

4. The target for policies within review date compliance for 2025/26 was initially set at 95% to be achieved by the end of March 2026. There has been some slippage of the 2025/26 programme which was top loaded for policy reviews in Quarters 1 and 2 to avoid the very busy Winter period. Due to vacancies, sickness, and competing directorate priorities including the Clinical Model Transformation Programme, the

following high priority policies were not brought through to the Policy Group for review or to be set on a consultation pathway:

- Safer Handling Policy
- Alternatives to Conveyance Policy
- Resourcing Policy
- Management of Safeguarding Allegations Policy
- High Risk Record Policy
- MPDS QA Policy
- Business Continuity Management Policy

The Resourcing Policy has an interdependency with the e-timesheet work.

5. Policy leads have provided revised timelines for the majority of these policies and a further review of the trajectory will be undertaken in Quarter 3. However, it is unlikely that we will reach 95% by March 2026, particularly as more policies will be due in the Policy Group during the Winter period. Having said that however, should all policies be presented on time for these quarters, the trajectory is currently tracking at 85%.

6. The Committee will recall that overall, Trust-owned policies within their revised dates was 14% in September 2023 and rose to 46% in March 2025. Once policies currently in the process are approved by board committees in Q3 that will rise to 50%, demonstrating a continued improvement trajectory. The end of year position will be reported to ARAC in May 2026.

7. Ongoing assurance against the work programme is provided via the established Alert, Advice, Assure (AAA) reporting mechanism. These reports are submitted to the ADLT following each Policy Group meeting to ensure appropriate oversight and escalation of issues.

8. The Trust has adopted 31 NHS Wales Policies, of which eight (26%) are currently within their review dates. These are managed externally by NHS Wales, and the Trust has limited control over their review cycles. Additionally, two further policies governed by Welsh Government and the Nursing and Midwifery Council (NMC) are monitored by the Trust but are also externally controlled.

Policy Transformation Programme

9. Planning will commence in Quarter 3 to map out the shape of a 2-3 year policy transformation programme. This will encompass the entire policy framework including a review of the existing policy development/approval process, update of the Policy on Policies, governance structures, policy templates and checklists, tools, training,

education and digital solutions. engagement with key stakeholders through a dedicated workshop.

RECOMMENDATIONS:

10. **Members are asked to:**

    a) **Note the adjustment to the 2025/26 policy work programme and that the review dates of several high priority policies are being recalibrated.**

    b) **Receive assurance on the progress to bring the Trust's Policies up to date.**

    c) **Note the direction of travel of the Policy Transformation Programme.**

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

REPORT APPROVAL ROUTE
12. Progress against the work plans was reported to ADLT via the monthly AAA following each Policy Group meeting and escalations made to the ELT as required.

REPORT ANNEXES
N/A

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

AGENDA ITEM No	**13**
OPEN or CLOSED	**Open**
No of ANNEXES	**0**

Assurance to ARAC on Speaking Up Safely Arrangements at WAST

MEETING	Audit, Risk and Assurance Committee
DATE	02 September 2025
EXECUTIVE	Ceri Jackson, Vice Chair of Trust Board Chair of People and Culture Committee
AUTHOR	Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The National Audit Office Effectiveness Tool requires that the Audit, Risk and Assurance Committee (ARAC) ensures the organisation operates appropriate and effective whistleblowing practices, and this is regularly considered by ARAC. The People and Culture Committee has the following mandate it its terms of reference which were approved by the Trust Board in May 2025: "3.9 *(a)-(c) Receive assurance that arrangements are in place to allow staff to raise concerns in confidence, ensure that those processes allow any such concerns to be investigated proportionately and independently, and receive assurance and that the learning from such concerns is considered and applied*".

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

3. The All-Wales Speaking Up Safely Framework was adopted by the People and Culture Committee in November 2023 and ratified by the Trust Board at its meeting in November 2023. A self-assessment against the framework as requested by Welsh Government was completed in 2023. On the 12 August 2025 the Committee received the first Annual Speaking Up Safely report.

4. Over the past year, WAST has made significant progress in embedding a culture of SUS. The appointment of a full-time Lead Guardian in June 2024 marked a milestone, making WAST the first in Wales to do so. This role has been pivotal in the implementation of the SUS framework and fostering a culture of openness and psychological safety across the organisation.

5. Staff and volunteers within the Trust can speak with a Speaking Up Safely Guardian in a completely confidential way. Guardians provide a valuable service that help improve patient safety, the safety of our people and working relations, whilst supporting wellbeing. People may want to speak with a Guardian about patient safety concerns, bullying and harassment or the safety of our people as well as many other things.

6. Whilst Guardians advocate that a conversation is had first with a staff members' line manager, if this is not possible for any reason, the Guardian is there to listen and support, offering safe and confidential space to talk through concerns. This can be done via Teams, phone, email, face to face or anonymously on the Work in Confidence (WiC) platform.

7. WAST's SUS arrangements were subject to an internal audit in 2024/25, which was received by the committee in May 2025 and received a 'reasonable' assurance opinion. This outcome reflects the Trust's commitment to creating an environment where staff feel safe and supported to raise concerns. The audit assessed the framework's effectiveness in preventing victimisation and promoting organisational learning through feedback mechanisms.

8. Within the 2024/25 reporting period, 113 SUS concerns were raised. Of these, 56% were submitted directly to Guardians and 44% via the WiC system. The performance data shows that staff are engaging with the guardian to raise concerns, though a temporary dip in quarter four highlights the importance of maintaining consistent resources and accessibility. The most common themes were inappropriate attitudes and behaviours (40.7%), bullying and harassment (22.1%), and staff safety and wellbeing (13.3%). While sexual safety concerns were less frequent (2.7%), their visibility has increased, suggesting growing confidence in addressing sensitive issues through multiple channels.

9. Confidentiality remains a key area for improvement. The data shows that many staff initially preferred anonymous or confidential reporting but shifted to open disclosure after engaging with the Guardian. This indicates growing trust in the process, though breaches in confidentiality continue to pose risks and require cultural reinforcement.

10. Several key themes have emerged: assumptions of inaction post-reporting, perceived bias in disciplinary processes, fear of retribution, and delays in investigations. In response, the WAST has a Workplace Standards process, a detriment risk assessment pilot, and additional resources to address these challenges. The launch of 'Our WAST Way' supports leadership development and essential conversations to tackle incivility and improve team dynamics.

11. The first year of the SUS initiative has laid strong foundations for the cultural transformation within WAST. On the 12 August 2025 the PCC endorsed the Trust-wide approach to integration of the SUS principles into leadership development, confidentiality practices, and equity and inclusion strategies. This unified approach will aid the normalisation of speaking up and listening as a leadership behaviour, reduce barriers to raising concerns, and ensure that all staff feel safe, respected and heard.

12. The SUS Guardians meet with me, as the Chair of the People and Culture Committee, the Chief Executive, and Director of Culture Change, on a quarterly basis to provide feedback on themes, areas of concern and to identify areas for improvement. Additionally, the PCC will continue to receive regular reports on these arrangements.

13. The Trust is committed to deepening the integration of SUS principles across all levels. Expansion of the Guardian team, improved feedback mechanisms, and stronger collaboration with safeguarding and people services will underpin this effort. The goal remains clear: to ensure every colleague feels empowered to speak up and confident that their voice will be heard and respected.

RECOMMENDATION:

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

KEY ISSUES/IMPLICATIONS
No issues to raise.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
n/a

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

Ymddiriedolaeth Brifysgol GIG
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AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

NEAR MISS AND LOW HARM INTELLIGENCE REPORT

MEETING	Audit, Risk and Assurance Committee
DATE	02 September 2025
EXECUTIVE	Bethan Evans, Non-Executive Director and Chair of the Quality, Patient Experience & Safety Committee
AUTHOR	Alex Payne, Corporate Governance Manager
CONTACT	Bethan.Evans24@wales.nhs.uk

EXECUTIVE SUMMARY

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

2. The purpose of this report is to provide assurance to the ARAC that the Quality, Patient Experience and Safety Committee (QuEST) received an update regarding the arrangements in the Trust relating to near miss and low harm incident reporting, and to provide assurance to the ARAC on the robustness of those arrangements.

3. The first Near Miss and Low Harm Intelligence Report was received in November 2024 and reported on the period from September 2022 to September 2024. At that time the QuEST Committee agreed that future reporting would be received in the quarterly Putting Things Right (PTR) Report, as opposed to via a separate near miss and low harm report.

4. At the QuEST Committee on the 05 August 2025 an update was received on the review of near miss incidents in quarter one 2025/26 PTR Report. This report advised that the review of near miss incidents has allowed issues to be identified early, with adjustments being made quickly to manage and mitigate risks. This position is stated in paragraph 11 of the relevant report taken to QuEST on the 04 August 2025.

5. Members heard that there are improvements to be made to the framework for recording and reporting of near miss incidents, and that consequently only limited assurance can be given at this time on the robustness of those arrangements. This is in part due to the increased complexity of investigations and activity associated with the Clinical Model Transformation Programme.

6. The Committee heard that recent changes to the clinical model and ongoing recruitment challenges in the Quality, Safety and Patient Experience and Operations Directorates have meant investigation capacity has not increased as expected; which has had an impact on the ability of the Trust to respond to and manage complaints and coronial workloads effectively.

7. Additionally, on the 04 August 2025 QuEST received the PTR Organisational Recovery Plan, which has been developed to address the backlog in complaints, coronial requests and incidents, the audit capacity requirements within Operations, the clinical investigation support from the Remote Clinical Care teams and the ongoing work of the PTR team. QuEST took assurance that the Executive Leadership Team required regular updates to monitor progress against the Recovery Plan. Noting the receipt of the Recovery Plan is relevant as it has, and will continue to have, an effect on the ability of the organisation to encourage a culture of reporting near miss and low harm incidents, and for the PTR Team to improve analysis on reporting to QuEST.

8. The focus for the Trust with regards to near miss and low harm reporting is therefore currently on the incidents that have taken place. The Executive Director of Quality and Nursing acknowledged the need to build a proactive near miss reporting culture as a priority, but this can only be developed after progress has been made on addressing the current challenges highlighted within the PTR Recovery Plan.

9. The QuEST Committee noted the position as presented and noted the limited assurance given on the robustness of the supporting framework and culture surrounding near miss and low harm reporting. Whilst the Committee received assurance on the commitment of teams and clarity of structure and actions to deliver required improvements (as indicated in the Recovery Plan), they voiced caution around ability to deliver in line with stated action, because of the extent of the current backlog and complexity of work being undertaken within this Team. The Committee identified gaps requiring urgent attention and has escalated its concerns regarding PTR to the Trust Board through its Alert, Advise and Assure Report dated 04 August 2025.

RECOMMENDATION:

10. **The ARAC Members are asked to consider the current position, and the concerns arising from this regarding the Trust's current ability to adequately record and report near miss and low harm incidents. Further, ARAC members are asked to note the Committee's receipt of the PTR Organisational Recovery Plan as part of its ongoing scrutiny of the issue.**

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Not applicable.

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

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

AGENDA ITEM No	**15**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1ST APRIL 2025 TO 31st JULY 2025

MEETING	Audit, Risk and Assurance Committee
DATE	2nd September 2025
EXECUTIVE	Chris Turley, Executive Director of Finance and Corporate Resources
AUTHOR	Jessica Price, Head of Financial Accounting
CONTACT	Jessica.Price3@wales.nhs.uk

EXECUTIVE SUMMARY

In accordance with SFI's this report presents to the Committee details of Losses and Special Payments made during the four months from 1st April 2025 to 31st July 2025 (**Annex 1**)

KEY ISSUES/IMPLICATIONS

Total net Losses and Special Payments made were as follows: -

- period 1st April 2025 to 31st July 2025 -£1.812m

REPORT APPROVAL ROUTE

Audit Committee 2nd September 2025 – no action required for information under SFI's only

REPORT APPENDICES
Annex 1 – Summary and details of payments made for the four months to 31st July 2025

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

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WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST
AUDIT, RISK AND ASSURANCE COMMITTEE
LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1st APRIL 2025 TO 31ST JULY 2025

SITUATION

1. In accordance with SFI's all losses and special payments made are to be reported to the Audit, Risk and Assurance Committee on a regular basis.

BACKGROUND

2. This report presents to the Committee details of Losses and Special Payments made during the four months from 1st April 2025 to 31st July 2025 (**Annex 1**).

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2025 to 31st July 2025 amounted to -£1.812 million.

4. This relates to actual payments made less reimbursements received from the Welsh Risk Pool (WRP) and does not relate to any adjustments made to the provision. During the four months to 31st July 2025 reimbursements received exceeded payment made by £1.812m.

5. During June 2025 you will note WRP reimbursements amounted to £1.020m. The vast majority of the reimbursement related to one case amounting to £0.926m in relation to a medical negligence claim in which an ambulance delay for a patient with a heart condition, following which the patient sadly died.

RECOMMENDED

6. That the Losses and Special Payments Report for this period be received.

Welsh Ambulance Services University NHS Trust
Losses and Special Payments

Annex 1

Summary of payments for the four months to 31st July 2025

	£
April 2025	-1,314,358.67
May 2025	66,430.59
June 2025	-649,094.89
July 2025	85,183.56
August 2025	-
September 2025	-
October 2025	-
November 2025	-
December 2025	-
January 2026	-
February 2026	-
March 2026	-
	-£1,811,839.41

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	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	389,417.36
Counsel fees		3,570.00	750.00	28,575.00	3,996.45	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	36,891.45
CRU		0.00	-2,412.50	5,177.00	913.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3,677.50
Damages		15,375.00	2,241.00	149,910.00	500.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	168,026.00
Defence Costs		12,678.08	-5,327.38	8,773.00	7,505.53	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	23,629.23
Expert Witness		11,405.00	2,930.00	7,490.00	7,500.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	29,325.00
Vehicle Repairs		21,074.64	18,212.91	20,240.59	6,168.58	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	65,696.72
WRP Refund		-1,518,526.19	0.00	-1,020,108.43	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-2,538,634.62
Property Repairs		395.00	0.00	9,747.95	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	10,142.95
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**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**-£1,811,839.41**

Welsh Ambulance Services University NHS Trust	Key	
Losses and Special Payments	MN	Medical Negligence
	PI	Personal Injury
Summary of payments for the four months to 31st July 2025	DP	Damage To Property
	£	
DP cases < £1,000	10,879.09	26 Cases
Redress cases < £1000	1,368.00	2 Cases
PI cases < £1000	3,617.00	6 Cases
25RT4MN0030	66.01	
26RT4MN0001	130.78	
25RT4MN0018	913.00	
22RT4MN0003	1,200.00	
25RT4MN0022	1,275.00	
23RT4MN0021	2,000.00	
25RT4MN0021	2,430.00	
25RT4MN0016	3,535.00	
25RT4MN0023	4,820.00	
25RT4MN0020	5,582.50	
24RT4MN0008	10,000.00	
18RT4MN0016	14,632.40	
23RT4MN0004	15,375.00	
24RT4MN0005	24,000.00	
24RT4MN0004	30,000.00	
22RT4MN0018	37,188.00	
24RT4MN0013	50,710.00	
18RT4MN0012	107,779.00	
21RT4MN0009	208,585.00	
24RT4PI0009	1,000.00	
24RT4PI0033	1,250.00	
24RT4PI0008	1,500.00	
22RT4PI0018	2,745.00	
26RT4PI0001	4,500.00	
24RT4PI0066	9,299.80	
24RT4PI0028	9,601.00	
21RT4PI0026	11,500.00	
22RT4PI0046	32,381.16	
26RT4GN0002	1,000.00	
24RT4GN0020	1,000.00	
22RT4GN0042	1,600.00	
24RT4GN0040	1,600.00	
23RT4GN0020	1,920.00	
26RT4GN0001	2,000.00	
24RT4GN0034	2,590.00	
23RT4GN0028	4,100.00	
23RT4GN0027	4,800.00	
23RT4GN0013	5,000.00	
25RT4EG0024	1,250.00	
25RT4EG0026	2,950.00	
25RT4EG0035	5,850.00	
26RT4EG0006	1,000.00	
26RT4EG0011	1,000.00	
26RT4DP0051	1,077.60	
26RT4EG0014	1,080.00	
26RT4DP0001	1,120.00	
26RT4DP0046	1,177.70	
26RT4DP0043	1,214.46	
26RT4DP0032	1,259.95	
26RT4DP0028	1,267.77	
26RT4DP0004	1,466.54	
26RT4EG0004	1,500.00	
26RT4DP0009	1,668.23	
26RT4DP0011	1,759.34	
26RT4DP0029	1,848.31	
26RT4DP0037	1,875.50	
26RT4EG0012	1,996.45	
26RT4EG0007	2,000.00	
26RT4DP0006	2,246.39	
26RT4EG0008	2,250.00	
26RT4EG0003	2,382.05	
26RT4DP0019	2,687.30	
26RT4DP0044	2,700.00	
26RT4DP0017	2,750.00	
26RT4DP0018	2,750.00	
26RT4DP0033	2,808.00	
26RT4DP0022	3,108.53	
26RT4DP0031	3,170.92	
26RT4DP0021	3,370.55	
26RT4DP0016	4,282.13	
26RT4DP0040	4,410.60	
26RT4DP0010	4,499.76	
26RT4DP0035	4,732.28	
26RT4DP0036	4,756.58	
26RT4DP0024	5,088.03	
26RT4DP0034	5,434.00	
26RT4EG0002	18,600.00	
22RT4MN0001	- 1,450,963.19	WRP REFUND
24RT4MN0009	- 961,854.78	WRP REFUND
20RT4MN0011	- 22,628.90	REFUND
20RT4MN0008	- 10,799.67	WRP Refund
19RT4PI0037	- 38,264.58	WRP Refund
21RT4PI0006	- 29,450.00	WRP REFUND
22RT4PI0006	- 19,985.00	WRP REFUND
20RT4PI0037	- 2,125.00	REFUND
24RT4PI0026	- 80.00	REFUND
23RT4GN0012	- 1,000.00	WRP REFUND
24RT4GN0038	- 800.00	WRP REFUND
24RT4GN0026	- 24,750.00	WRP Refund
24RT4GN0031	- 500.00	WRP Refund
24RT4GN0039	- 500.00	WRP Refund
Total	**- 1,811,839.41**	

Welsh Ambulance Services University NHS Trust
Jun-25

Case Reference	Details	Amount (£)
21RT4PI0026	PROFESSIONAL FEES	400.00
22RT4PI0006	COURT FEE	545.00
24RT4PI0009	COUNSEL FEES	1,000.00
18RT4MN0016	COUNSEL FEES	1,600.00
21RT4MN0009	COUNSEL FEES	1,925.00
22RT4MN0003	COUNSEL FEES	1,200.00
23RT4MN0021	EXPERT WITNESS	2,000.00
24RT4MN0013	PROFESSIONAL SERVICES	1,210.00
25RT4MN0020	EXPERT WITNESS	490.00
26RT4DP0032	DAMAGE TO PROPERTY	1,259.95
26RT4DP0029	TP VEHICLE REPAIRS	348.31
26RT4EG0002	COUNSEL FEES	18,600.00
26RT4EG0006	COUNSEL FEES	1,000.00
26RT4EG0007	COUNSEL FEES	2,000.00
26RT4DP0033	DAMAGE TO PROPERTY	2,808.00
26RT4DP0034	DAMAGE TO PROPERTY	5,434.00
25RT4EG0024	COUNSEL FEES	1,250.00
26RT4DP0035	TP VEHICLE REPAIRS	4,732.28
26RT4DP0036	TP VEHICLE REPAIRS	89.10
26RT4DP0036	TP VEHICLE REPAIRS	4,667.48
26RT4DP0037	TP VEHICLE REPAIRS	1,875.50
26RT4DP0031	COURT FEE	455.00
26RT4DP0038	DAMAGE TO PROPERTY	246.00
25RT4EG0035	PROFESSIONAL FEES	5,850.00
16RT4MN0009	WRP REIMBURSEMENT	- 925,941.78
19RT4PI0037	WRP REIMBURSEMENT	- 38,264.58
20RT4MN0008	WRP REIMBURSEMENT	- 10,799.67
24RT4GN0026	WRP REIMBURSEMENT	- 24,750.00
24RT4GN0039	WRP REIMBURSEMENT	- 500.00
22RT4MN0011	WRP REIMBURSEMENT	- 19,352.40
24RT4GN0031	WRP REIMBURSEMENT	- 500.00
22RT4PI0018	CRU	2,745.00
22RT4PI0046	CRU	915.00
18RT4MN0012	CRU	829.00
21RT4MN0009	GENERAL DAMAGES SETTLEMENT	131,660.00
21RT4MN0009	CLAIMANTS SOLICITORS FEE	75,000.00
22RT4MN0018	CRU	688.00
24RT4MN0004	CLAIMANTS SOLICITORS FEE	15,000.00
24RT4MN0004	GENERAL DAMAGES SETTLEMENT	15,000.00
24RT4MN0013	CLAIMANTS SOLICITORS FEE	49,500.00
23RT4GN0013	EXPERT WITNESS	5,000.00
24RT4PI0041	COURT FEES	313.00
26RT4EG0008	EX-GRATIA	2,250.00
26RT4DP0040	TP VEHICLE REPAIRS	3,009.00
26RT4DP0040	TP VEHICLE REPAIRS	1,401.60
26RT4DP0031	TP VEHICLE REPAIRS	2,715.92
26RT4DP0007	TP VEHICLE REPAIRS	809.00
25RT4DP0158	TP VEHICLE REPAIRS	592.40
23RT4GN0027	SOLICITORS COSTS	1,600.00
26RT4GN0002	GENERAL DAMAGES SETTLEMENT	1,000.00
Totals		**- 649,094.89**

Welsh Ambulance Services University NHS Trust
Jul-25

Case Reference	Details	Amount (£)
24RT4PI0008	COUNSEL FEES	1,500.00
24RT4PI0047	COUNSEL FEES	500.00
25RT4MN0016	EXPERT WITNESS	990.00
25RT4MN0020	PROFESSIONAL FEES	2,537.50
25RT4MN0023	EXPERT WITNESS	3,920.00
26RT4DP0043	TP VEHICLE REPAIR	1,214.46
26RT4EG0009	TRANSCRIPTION SERVICES	110.22
26RT4DP0044	PROFESSIONAL FEES	2,700.00
26RT4EG0010	TRANSCRIPTION SERVICES	46.24
26RT4EG0011	PROFESSIONAL FEES	1,000.00
26RT4EG0012	COUNSEL FEES	1,996.45
26RT4EG0013	TRANSCRIPTION SERVICES	31.57
26RT4DP0029	TP VEHICLE REPAIR	1,500.00
26RT4DP0046	TP VEHICLE REPAIR	1,177.70
26RT4EG0014	PROFESSIONAL FEES	1,080.00
26RT4DP0047	TP VEHICLE REPAIR	258.84
26RT4DP0048	TP VEHICLE REPAIR	814.08
26RT4DP0049	TP VEHICLE REPAIR	125.90
26RT4DP0051	TP VEHICLE REPAIR	1,077.60
22RT4MN0018	CLAIMANTS SOLICITORS FEES	33,000.00
24RT4MN0005	CLAIMANTS SOLICITORS FEES	24,000.00
25RT4MN0018	CRU	913.00
24RT4GN0034	EXPERT WITNESS	2,590.00
24RT4GN0040	PROFESSIONAL FEE	1,600.00
24RT4GN0044	GENERAL DAMAGES SETTLEMENT	500.00
Totals		**85,183.56**

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

AGENDA ITEM No	**16**
OPEN or CLOSED	**Open**
No of ANNEXES	**1**

Committee Monitoring Report and Priorities Update 2025/26

MEETING	Audit, Risk and Assurance Committee
DATE	02 September 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Sarah Harland, Corporate Governance Officer
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report updates the Audit, Risk and Assurance Committee (ARAC) on progress against the priority it set for 2025/26 and progress against the agreed Cycle of Business for the Committee. There are no matters to escalate to the Committee from the Cycle of Business.

RECOMMENDATION: -

2. **The Committee is asked to: -**
   To note the update on the Cycle of Business Monitoring Report for the Committee and the position against its annual priority.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Annex 1 – ARAC Cycle of Business Monitoring Report – September 2025

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

COMMITTEE PRIORITIES FOR 2025/26 AND CYCLE MONITORING REPORT

SITUATION

3. This report updates the Committee on progress against the priorities it set for 2025/26 and progress against the agreed Cycle of business. There are no matters to escalate to the Committee from the Cycle of Business.

BACKGROUND

4. During the course of the effectiveness reviews, it was agreed that it is good practice for committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2025 and will be tracked quarterly.

5. The Committee's cycle of business was approved by the Committee in May 2025. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

6. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports.

7. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or is an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but has been deferred to a future meeting.

ASSESSMENT

8. The Committee priority for 2025/26 and progress against it is as follows:

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.	• A project plan has been agreed with a sub-group of ARAC. The Director of Corporate Governance/Board Secretary is presenting a paper at the meeting of the Audit Risk and Assurance Committee on 2 September 2025 regarding the 2025/26 Effectiveness Review and is facilitating an ongoing discussion with a sub-group of ARAC regarding this work.

RECOMMENDATION: -

9. **The Committee is asked to: -**
   To note the update on the Cycle of Business Monitoring Report for the Committee and the position against its annual priority.

PAPER	PRE or POST C'EE FORUM	FREQUENCY	Q1a	Q1b	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
AUDIT, RISK AND ASSURANCE COMMITTEE - CYCLE OF BUSINESS 2025/26										
For the rationale for this Committee's cycle see Note 8										
Annual filings										
Annual accounts planning and emerging issues report	ELT	Annually						EDOF	Assurance	
Annual report timetable	ELT	Annually						BS	Assurance	
Audited accounts	ELT and Board	Annually						EDOF	Endorsement	
Annual report	ELT and Board	Annually						BS	Endorsement	
Head of internal audit report and opinion	ELT and Board	Annually						Internal Audit	Assurance	
Audit report on accounts	ELT and Board	Annually						Audit Wales	Assurance	
Self-assessment against Governance Code 2017	ELT	Annually						BS	Assurance	
Internal Audit										
Audit Plan	ELT	Annually						Internal Audit	Approval	
Internal audit reports	ELT and C'ees	Quarterly						Internal Audit	Assurance	Relevant directors to be in attendance for limited assurance reviews
Audit Wales										
Audit Plan	ELT and Board	Annually						Audit Wales	Review	SFI 3.4.1 AC must ensure cost efficient external audit service is delivered; SFI 3.4.3 AC to review plan and associated costs. Noted to Board
Update report	N/A	Quartlery						Audit Wales	Assurance	
Annual Audit Report	ELT and Board	Annually						Audit Wales	Assurance	Audit report for calendar year. Copy to Board in AAA
Structured Assessment	ELT and Board	Annually						Audit Wales	Assurance	May also be presented at other times depending upon audit plan
Other Non-Core Reports	ELT and Board	Various						Audit Wales	Assurance	Non-core reports are those outside of the Structured Assessment work and are included in the Audit Plan
Losses & Special Payments/Single Tender Waivers										
Quarterly lossess and special payments report	N/A	Quarterly						EDOF	Approval	See Note 1
Tender update report and single tender waiver request	N/A	Quarterly						EDOF	Assurance	Closed session
Counter fraud										
Counter fraud update report	N/A	Quarterly						EDOF	Assurance	Closed session. See Note 6
Counter fraud annual report	ELT	Annually						EDOF	Assurance	Closed session. See Note 6 Not to go to Board - only ARAC
Counter fraud update work plan	ELT	Annually						EDOF	Approval	Closed session. See Note 6
Standing Orders & Standing Financial Instructions										
Standing Orders & Standing Financial Instructions	ELT and Board	Annually		→				BS	Endorsement	Q4 24-25: Revised for 2025, however SFI changes will be coming forward for Q2 ARAC 25-26.
Breach of Standing Orders & Standing Fin. Instructions	ELT	Ad Hoc						BS	Discussion/Assurance	
Governance Practice Notes	ELT	Annually						BS	Approval	Q1b: Review not required in 2025; reference in the monitoring report update.
Whistleblower, Declarations, Gifts & Hospitality										
Annual report on declarations of interest	ELT	Annually						BS	Assurance	
Report on gifts and hospitality	ELT	Annually						BS	Assurance	
Whistleblower (speaking up safely) report	TBC	TBC						BS	TBC	See Note 2
Other										
Near Miss Report	QUEST	Annually						BS	Assurance	See Note 3
Policy										
Policy report	ELT	Quarterly						BS	Assurance	Position on policies including those outstanding for review etc. See Note 4
Policies	Policy Group	Ad Hoc						BS	Approval	Policies within the purview of this Committee - see Note 5
Financial procedures	TBC	Ad Hoc						EDOF	Approval	SFI 1.1.3 all financial procedures must be approved by the EDOF and Audit Committee
Risk Management										
Review of risk related elements in IMTP	STB	Annually						BS	Assurance	
Board Assurance Framework	ELT	Each meeting						BS	Assurance	
Corporate Risk Register	ELT	Each meeting						BS	Assurance	
Audit Recommendation Tracker	ELT	Each meeting						BS	Assurance	
GOVERNANCE										
Escalations from Board Committees	Board Committee	Ad Hoc						Committee Chair	Various	
Committee effectiveness reviews and annual reports	All Committees	Annually						BS	Approval	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.

2004/25

REPORT BACK

All Wales NHS Audit Committee Chairs Group

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“a vibrant community where we reflect, learn, and support each other. It is a place of curiosity, innovation, and connectivity, where ideas flourish, and collaboration thrives.”

Audit committee chairs in the NHS oversee the governance arrangements for the NHS' £10 billion plus budget in Wales. We help to ensure that money is spent wisely to benefit our communities. How do we do that? We rigorously review the effectiveness of our systems of controls and governance, driven by a commitment to excellence.

For instance, we ensure robust financial reporting and control mechanisms that supports transparency and accountability in the allocation of public funds. We check that we all have comprehensive risk management frameworks designed to proactively identify and mitigate potential threats, including to patient safety and service delivery. We also help to ensure that the NHS learns and acts on lessons from external and internal audit.

The role of audit committees continues to evolve. It is not just about core financial accounts and systems of control. As a group we’ve discussed the growing challenges around new threats, such as counter fraud as well as the challenges of balancing risk management with innovation and transformation.

The All-Wales NHS Audit Committee Chairs Group provides a vibrant community where we reflect, learn, and support each other. It is a place of curiosity, innovation, and connectivity, where ideas flourish, and collaboration thrives. I hope this summary report serves as a reminder of the pivotal role audit committee chairs play across the NHS.

Nuria Zolle, Chair of the All-Wales NHS Audit Committee Group

Summary of key issues discussed in 2024-25

We're getting the system back on track after the pandemic

During the pandemic a lot of work was postponed or delayed, including audit work. As a result, the timetable for producing, auditing and signing off accounts across the NHS slipped backwards. Over recent years there has been a concerted effort from Audit Wales and finance teams across the NHS to get things back on track. Audit committees have welcomed the extra efforts being made across the system, and the resulting pressures for everybody. A huge thank you to everybody!

Ensuring our risk and assurance frameworks incentivise the right behaviours

Across Wales risk management and board assurance frameworks continue to evolve. Each body is at a different level of maturity. Overall, the level of risk across the NHS, post pandemic remains high. The danger is that this leads to a defensive 'fire-fighting' mindset. While of course, we must manage risk and prevent harm we also need our systems to incentivise transformation and innovation for the long-term. Getting that balance right is a growing focus of audit committees, not least in the context of our duties to future generations.

Navigating governance arrangements across public bodies

The governance landscape in which NHS bodies operate grows ever more complex. Audit committees oversee board governance arrangements that interact with regional and national NHS systems, including commissioning. The role also involves overseeing multi sectorial partnership governance arrangements and agreements. Keeping on top of these and ensuring everything is aligned and coherent is a growing challenge for audit committees.

Counter fraud and cybersecurity are evolving areas of work

Across the UK, the NHS is vulnerable to £1.316 billion worth of fraud each year. The threat of counter fraud and cybersecurity has become an increasing risk for the NHS. As the threats evolves so do the NHS counter fraud arrangements. Shared learning and shared systems of assurance across NHS Wales are enhancing local control arrangements.

Applying the learning from audit inspections and reviews

Audit and inspection are a key part of our governance system. Audit committees are noticing growing strain across the system in delivering a timely response to recommendations. We recognise that there are competing priorities with pressure to deliver on day-to-day service issues. And there can also be challenges where local action depends on national systems, like IT systems which can be delayed.

However, audit recommendations are often a means to addressing systemic issues that hamper effective and efficient service delivery in the long-run. Audit committees are increasingly focussing on:

(a) challenging our organisations to set realistic timescales for implementing recommendations and prioritise action to deliver within those timeframes; and

(b) holding executives to account for not delivering on time and pressing for clear action, especially in those areas that relate to patient outcomes.

Operating arrangements of the NHS all Wales audit committee chairs group

The chairs of the Audit Committee Group was established to provide an opportunity for Wales-wide discussions on emerging issues on governance, risk management, financial controls, cyber security and counter fraud.

Scope and duties

The scope and duties of the group will comprise:

- Discussion of common issues arising from internal and external audit reviews.
- Discussion of the highest risks relating to governance, nationally and locally.
- Sharing cultural and thematic challenges and good practice and learning.

Items to be placed on the agenda will be informed by the group's action plan but can come from several sources such as those below but are not limited to:

- Group members.
- Board or trust committees.
- Chair, vice-chair and other members of the boards.
- Directors of Corporate Governance/board secretaries' network or other all-Wales peer groups.
- Audit Wales and Internal Audit.
- NHS Counter Fraud authority.

Membership

The membership will comprise chairs of Audit committees across Wales.

Should an NHS body Audit Committee Chair be unable to attend, a representative from the organisations will be identified by the body's Audit Chair.

Meetings

Hosting

The hosting organisation of the group will rotate every year.

Quorum

At least six members must be present to ensure the quorum.

Chair

The group will nominate a member to chair and this will rotate on a yearly basis.

Secretariat

The Director of Corporate Governance/Board Secretary of the hosting organisation will determine the secretarial and support arrangements for the group.

Frequency of Meetings

Meetings shall be held quarterly. Thematic working groups will be convened as and when required.

Committee Meetings

A standard agenda will be used as the basis for discussion at each meeting. Notes prepared following a meeting shall be circulated to members and retained by the relevant Director of Corporate Governance/Board Secretary as a formal record of the decision making for a period of seven years.

Withdrawal of individuals in attendance

The group 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 on any matter.

Last reviewed in July 2024

Big thanks!

Thank you to those who have supported the work of the committee

Commissioning arrangements

Chairs would like to thank Abi Harris who was Chief Executive of the NHS Commissioning Service for sharing an oversight of the new governance arrangements.

Audit Wales and Internal Audit

Chairs would like to thank Simon Cookson, Anne Beagan, Dave Thomas and Anthony Veale and Andrew Doughton for providing regular insights and updates. These included updates and insights in relation to new accounting systems and methodologies, risk management, thematics and analysis on areas of limited assurance, as well as findings from local and national reviews.

Audit Trackers

Chairs would like to thank Joanne Wilson and colleagues in Hywel Dda Health Board for openly sharing ideas and progress in relation to the development and implementation of their audit tracker.

Counter fraud activity

Chairs would like to thank Matthew Evans and colleagues for updates in relation to new national initiatives and activities as well as key learning from counter fraud activity in relation to detection and prevention.

Board Governance and oversight

Chairs would like to thank Hazel Lloyd for providing regular updates to the group in relation to the All Wales Director of Governance agenda and insights. We would also like to thank board directors for agreeing to review the training and development offered to Audit Committee Chairs across the NHS.

Board Assurance Framework

Chairs would like to thank Chris Darling for sharing Digital and Health Care Wales board assurance framework.

2024/ 25 Sharing learning and practice

Chairs also discussed and shared ideas on several areas including but not limited to; balancing competing priorities, time commitments, efficiency reviews, HMCA guidance reports, system improvements and NHS finances, committee reviews.

Looking forwards

A new work plan for 2024/ 25 is in the process of being agreed areas for discussion are likely to include:

- Financial savings, sustainability and recovery
- New counter fraud arrangements and directives
- Partnership governance arrangements

Group Membership

Health Boards

Iwan Jones, Aneurin Bevan University Health Board

Karen Balmer, Betsi Cadwaladr University Health Board

Dr RhianThomas, Cardiff and Vale University Health Board

Patsy Roseblade, Cwm Taf Morgannwg University Health Board

Rhodri Evans, Hywel Dda University Health Board

Steve Elliot, Powys Teaching Health Board

Nuria Zolle, Swansea Bay University Health Board

All-Wales NHS Trusts

Marian Wyn Jones,Digital Health and Care Wales

Jayne Sadgrove, Health Improvement Wales

Peter Curran, Welsh Ambulance Services

Gareth Jones, Velindre University Trust

Nick Elliot, Public Health Wales

Joint Notice: Corporate Governance Directorate and Finance and Corporate Resources Directorate

15 July 2025

Contract Management

Following a recent audit of contract management processes WAST-2425-03-Contract Management_Final Advisory Report.pdf, and ahead of further training and guidance being developed by NWSSP Procurement Services, we are writing to remind all **budget holders and managers** of their key responsibilities when entering into and managing contracts on behalf of the organisation.

These steps will help us ensure we maintain effective and consistent contract management across the organisation, while complying with our Standing Financial Instructions and supporting delivery of value and transparency in line with NHS Wales principles.

Please take time to review and apply the following:

Check the Standing Financial Instructions (SFIs)

WAST Standing Orders - Schedule 2.1 Standing Financial Instructions v5 (approved 270122)

- Our SFIs include the organisation's core requirements for Procurement activity (in chapter 11).
- Recent updates to the SFIs will shortly be made to reflect new requirements under the Social Partnership and Procurement Act 2023. Further detail on this will be forthcoming shortly.
- Once national guidance is issued, we will update local policies where necessary and provide links to centralised training materials to support contract managers.
- In the meantime, please ensure you **follow the current SFIs** and approved procurement processes when initiating procurement or entering into a contract.

Ref: 2025-006

Approved by: Trish Mills,
Director of Corporate Governance
and Board Secretary

Check your delegated authority

- Before progressing:
  - Confirm you have the appropriate delegated authority (per the Scheme of Reservation and Delegation) to:
    - Go out to tender / commence procurement
    - Enter into and sign a contract
  - Ensure that you also have an approved and sufficient budget for the full value of the contract.

- If in doubt, please check with your line manager, FinCoR (for budget and procurement processes) or CorGov (for delegated authority and approvals required by Trust Board).

Nominate a Contract Manager for each contract

- Every contract must have a clearly identified Contract Manager, responsible for:
  - Performance oversight: ensuring that goods/services are delivered as agreed, in line with KPIs or service standards.
  - Financial oversight: ensuring that spend is in line with the approved budget; monitoring invoicing, payments, and potential financial risks.

- It is anticipated as a result of this internal audit review that central training on Contract Manager responsibilities will follow, but for now, please:
  - Nominate a named Contract Manager for each contract.
  - Ensure that the Contract Manager understands these key responsibilities and documents their oversight activities.

Maintain a Directorate-level Contract Register

- Each Directorate should maintain an up-to-date Contract Register to support effective oversight and audit readiness.
- At a minimum, your register should include:
  - Contract title
  - Supplier name
  - Contract value
  - Contract start and end dates

    - Named Contract Manager
    - Key performance indicators / reporting requirements
- Maintaining a Contract Register helps to:
    - Track key dates such as contract start/end dates, renewal periods, and key milestones.
    - Support compliance and risk management by recording key terms, obligations, and potential risks.
    - Provide a clear audit trail, including amendments and performance evaluations.
    - Serve as a central reference point for legal, procurement, finance, and contract managers.
    - Improve communication and shared understanding across departments about contract responsibilities.
    - Enable budget and financial tracking — monitoring contract values, payment terms, and supporting forecasting.

- Lisa Trounce (Head of Compliance and Assurance), is available as an internal contact to share the initial central Contract Register template used for the recent audit. Please contact Lisa direct via lisa.trounce@wales.nhs.uk if your Directorate does not yet have a current register in place.

Reporting and escalation

- Contract performance and risks should be routinely reviewed and reported through your Directorate Management Team meetings as a first step.
- Significant risks (financial, delivery or compliance-related) should be escalated through Directorate where appropriate, bearing in mind the risk, value, complexity and strategic importance of the contract.
- Timely escalation is key to ensuring risks can be managed effectively and consistently across the organisation.

Summary

Entering into and managing contracts creates legally binding obligations on WAST. Robust contract management protects both the organisation and NHS Wales as a whole - financially, operationally, and reputationally.

Please ensure that your teams are applying the above points consistently in current and future procurement and contract management activity.

If you have any questions or need support:

- Contact Lisa Trounce (Head of Compliance and Assurance) for the Contract Register template.

- Contact either Jason Collins, (Head of Financial Management), or Ed Roberts (Head of Financial Business Intelligence and Capital Planning) within the Finance and Corporate Resources Directorate, and Julie Boalch (Assistant Director of Corporate Governance and Risk) for questions on SFIs, authorisation, or contract oversight.

Thank you for your attention to this important matter.

Trish Mills
Director of Corporate Governance / Board Secretary

Chris Turley
Executive Director of Finance and Corporate Resources