Bundle Audit, Risk and Assurance Committee (Open) 28 April 2026

Agenda attachments
 00 Agenda

0 09:30 - OPENING ITEMS

1 Chair's Welcome, Apologies and Quorum

2 Declarations of Interest
 Item 02 Board Member Register of Interests as at 10 April 2026

3 Minutes of the last meeting held on 2 March 2026
 Item 03 2026-03-02 Draft ARAC Public Minutes

4.1 Action Log and Matters Arising
 Item 04.1 Action and Decisions Log (Public) Audit, Risk and Assurance Committee

4.2 Committee AAA Highlight Report: 2 March 2026
 Item 04.2 ARAC AAA Highlight Report 2 March 2026

4.3 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:35 - 2025/26 Annual Reports from Committees
 Item 05 ARAC Quality and Governance Review
 Item 05 Annex 1 APC Annual Report 2025-26 for ARAC
 Item 05 Annex 2 Charity Committee Annual Report 2025-26 for ARAC
 Item 05 Annex 3 FPC Annual Report 2025-26 for ARAC
 Item 05 Annex 4 PCC Annual Report 2025-26 for ARAC
 Item 05 Annex 5 QuESt Annual Report 2025-26 for ARAC
 Item 05 Annex 6 RemCom Annual Report 2025-26 for ARAC
 Item 05 Annex 7 ARAC Annual Report 2025-26 for ARAC 28 April 2026
 Item 05 Annex 8 ARAC Cycle of Business 2026-27 for approval by ARAC 280426
 Item 05 Annex 8 Notes

6 10:35 - Internal Audit

6.1 Internal Audit Progress Report
 Item 06.1 Internal Audit Progress Report April 26

6.2 Internal Audit Reports
6.2.1 Risk Management and Assurance (TM) [Reasonable Assurance]
6.2.2 Welsh Language Standards (TM) [Reasonable Assurance]
6.2.3 Capacity Management Plan (Ambulance Care) (LB) [Reasonable Assurance]
6.2.4 Job Evaluation (CK) [Reasonable Assurance]
 Item 06.2.1 Risk Management Board Assurance Final Report
 Item 06.2.2 Welsh Language Standards Final Internal Audit Report
 Item 06.2.3 Capacity Management Plan Final Internal Audit Report
 Item 06.2.4 Job Evaluation Final Internal Audit Report

7 12:05 - Audit Wales

7.1 Audit Committee Update April 2026
 Item 07.1 Audit Wales Audit Committee Update April 2026

7.2 Audit Wales Detailed Audit Plan 2026
 Item 07.2 Audit Wales Detailed Audit Plan 2026

7.3 12:15 - COMFORT BREAK

8 12:30 - Register of Interests and Gifts, Hospitality and Sponsorship
 Item 08 Register of Interests and Gifts Hospitality and Sponsorship

Item 08 Annex 3 Declarations of Gifts and Hospitality 2025-26 Register

9 12:40 - Self Assessment against 2017 Corporate Governance Code for Central Government Departments Review

Item 09 Review of Code of Gov for Central Gov Dept, ARAC 280426
Item 09 Annex 1 2026 Review WAST Self Assessment against Code of Governance 2017

10 12:50 - Review of Governance Practice Notes

Item 10 GPN cover for ARAC 280426
Item 10 Annex 1 2026-27 Governance Practice Note 001 v2, for approval by ARAC 28042026
Item 10 Annex 2 2026-27 Governance Practice Note 002 v4, for approval by ARAC 28042026
Item 10 Annex 3 2026-27 Governance Practice Note 003 v3, for approval by ARAC 28042026

10.1 12:55 - CONSENT ITEMS - None

10.2 12:55 - CLOSING ITEMS

11 Reflections

12 Any Other Business

13 Date & Time of the next meeting: 23 June 2026 at 9:30am

Length of Meeting: 03:30 | Agenda Status:

[PUBLIC] AUDIT, RISK AND ASSURANCE COMMITTEE - 28 APRIL 2026

Deadline for Papers: 17 April 2026

Last good practice Exec Review: 8 April 2026

Time	Mins allotted	Agendum	Title	Format	Item for	Item requested by	Paper prepared by	Item presented by	Colleagues to cc	Scheduled at ELT	Further approval route (if app.)	Notes
			OPENING ITEMS									
09:30	00:05	1	Chair's Welcome, Apologies and Quorum	Verbal	Information	Standing	n/a	Chair	n/a			
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a			
		3	Minutes of the last meeting held on 2 March 2026	Paper	Approval	Standing	n/a	Chair	n/a			
		4	4.1 Action Log & Matters Arising: 4.2 Committee AAA Highlight Report: 2 March 2026	Paper	Discussion	Standing	n/a	Chair	n/a			
			FOR APPROVAL, ASSURANCE AND DISCUSSION									
09:35	01:00	5	2025/26 Annual Reports from Committees	Paper	Assurance	CoB	CorGov	Trish Mills	Julie Boalch Alex Payne			
10:35	01:30	6	**Internal Audit** 6.1 Internal Audit Progress Report 6.2 Internal Audit Reports 6.2.1 Risk Management and Board Assurance Framework (TM) [Reasonable Assurance] 6.2.2 Welsh Language Standards (TM) [Reasonable Assurance] 6.2.3 Capacity Management Plan (Ambulance Care) (LB) [Reasonable Assurance] 6.2.4 Job Evaluation (CK) [Reasonable Assurance]	Paper	Assurance	CoB	Internal Audit	Osian Lloyd	Felicity Quance			
12:05	00:10	7	**Audit Wales** 7.1 Audit Risk and Assurance Committee Update April 2026 7.2 Detailed Audit Plan 2026	Paper	Endorsement	AdHoc	External Audit	Fflur Jones	Yvonne Thomas			
12:15	00:15		COMFORT BREAK									
12:30	00:10	8	Register of Interests and Gifts, Hospitality and Sponsorship	Paper	Assurance	CoB	CorGov	Trish Mills	Lisa Trounce			
12:40	00:10	9	Self Assessment against 2017 Corporate Governance Code for Central Government Departments 2027: 2026 Code Review	Paper	Assurance	CoB	CorGov	Trish Mills	Julie Boalch Alex Payne			
12:50	00:05	10	Review of Governance Practice Notes	Papers	Approval	CoB	CorGov	Trish Mills	Alex Payne			
			CONSENT ITEMS - None									
			CLOSING ITEMS									
12:55	00:05	11	Reflections	Verbal	Discussion	Standing	n/a	Chair	n/a			
		12	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a			
		13	Date & Time of the next meeting: 23 June 2026 at 9:30am	Verbal	Information	Standing	n/a	Chair	n/a			
13:00	**03:30**		**CLOSE**									

LEAD PRESENTERS

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

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		08-Feb-26
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1985		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	**Non-Executive Director** * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
BROOKS, Lee	**Executive Director of Operations**	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
CURRAN, Peter	**Non-Executive Director** * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022	17 July 2025	
		Chair - Taff Housing Association	Any Other Interest	17 July 2025		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022	31 October 2024	
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024	30 September 2025	
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015	January 2025	
		Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director - Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Chair - North Devon Homes	Position in Charity or Voluntary Organisation	01 October 2021	January 2025	
		Company Director - North Devon Homes	Directorships	01 April 2022		
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Chief Executive Officer (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at Beacon Housing (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Moorlands Property Ltd	Directorships	16 August 2022		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		Companty Director - Springfield Property Lettings Ltd	Directorships	16 August 2022		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	*Directorships*	*12 March 2020*		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
EVANS, Bethan **[continued]**	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024		
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024		
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024		
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024		
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024		
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024		
		Company Director - The Mountains Property Ltd	Directorships	09 December 2024		
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025		
HUTCHINGS, Hayley	**Non-Executive Director** * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Emeritus Professor, Swansea University	Non-Financial Professional	31 May 2025		
		Consultancy (temporary cover for the Director of Operations - Clinical Trials Unit) at Wolverhampton University	Financial Interest	10 October 2025	31 December 2025	
		Consultant Advisor to the FASAR Trial, Nottingham Trent University	Financial Interest	25 March 2026		
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROBERTS, Edward	**Interim Finance Director (from 09 September 2025)**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017	31 March 2025	
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023	2 June 2025	
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025		
		Co-opted into the BCS Community Board	Any Other Interest	12 August 2025	11 August 2026	
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	**Trade Union Partner**	Nil Declaration				

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Date Left Trust
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		
		Vice Chair - Royal College of Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	03 February 2025		
WOOD, Emma	**Chief Executive (from 01 October 2025)**	Chartered Fellow of CIPD (Chartered Institute of Personnel and Development)	Non-Financial Professional	2000		
		External Moderator for HR Masters modules for University West of England	Financial Interest	September 2024	21 January 2026	
		Member of Yoga Professional Alliance	Non-Financial Personal	July 2025		
		Part-time Yoga Teacher at Burnham Swim and Sports Academy Leisure Centre	Financial Interest	July 2025		
		Sub/Relief Yoga Teacher at Omni Studio, Worle, Norh Somerset	Financial Interest	04 April 2026		

UNCONFIRMED MINUTES OF THE PUBLIC MEETING OF THE AUDIT RISK AND ASSURANCE COMMITTEE ON MONDAY 2 MARCH 2026 HELD AT THE CARDIFF MAKE READY DEPOT AND VIA TEAMS

Meeting started at 09:30

PRESENT:

Peter Curran	Non-Executive Director and Committee Chair
Hayley Hutchings	Non-Executive Director
Ceri Jackson	Non-Executive Director
Julie Boalch	Assistant Director of Corporate Governance and Risk
Judith Bryce	Assistant Director of Operations
Christian Fox	Trade Union Partner
Fflur Jones	Audit Wales
Trish Mills	Director of Corporate Governance/Board Secretary
Osian Lloyd	Head of Internal Audit, NWSSP Internal Audit
Liz Rogers	Deputy Director of People and Culture *(Deputising for Carl Kneeshaw)*
Chris Turley	Executive Director of Finance and Corporate Resources
Liam Williams	Executive Director of Quality and Nursing
Carl Window	Local Counter Fraud Manager

ATTENDEES:

Jill Gill	Head of Financial Accounting
Sarah Harland	Corporate Governance Officer
Rachel Marsh	Executive Director of Strategy Planning and Performance *(for Item 5.3.2)*
Alex Payne	Corporate Governance Manager
Leanne Smith	Assistant Director of Digital Services *(Deputising for Jonny Sammut for Item 11)*
Andy Swinburn	Executive Director of Paramedicine *(for Item 5.3.3)*
Yvonne Thomas	Audit Wales
Felicity Quance	Deputy Head of Internal Audit

OBSERVING:

Toni-Marie Norman	Business Manager
Janice Smith	Good Governance Institute
Charlotte Wilmshurt	Assistant Director of Assurance and Risk *(Hywell Dda University Health Board)*
AnnaMaria Williams	Corporate Governance Officer

DRAFT

APOLOGIES:

Carl Kneeshaw	Director of People
Jonny Sammut	Director of Digital Services
Damon Turner	Trade Union Partner

OPENING ITEMS

1. CHAIR'S WELCOME, APOLOGIES AND QUORUM

1.1 Apologies from Carl Kneeshaw, Jonny Sammut and Damon Turner were noted. Quorum was confirmed.

2. DECLARATIONS OF INTEREST

2.1 There were no other declarations recorded.

3. MINUTES OF THE LAST MEETING HELD ON 2 DECEMBER 2025

3.1 Ceri Jackson proposed an amendment to the minutes of the public meeting of the Audit Risk and Assurance Committee held on 2 December 2025. At Item 10.2, paragraph 2, it was agreed that the word *"real"* be replaced with *"significant"*. Subject to this amendment, the minutes were approved.

4.1 ACTION LOG

4.1.1 The Action Log was received and updated.
Action 14.2/02092025 Assurance to ARAC on Near Miss and Low Harm Intelligence Framework *Trish Mills suggested that, instead of scheduling a fixed six-month report to ARAC, the committee should use the AAA (alert, advise, assure) process to formally request Quest to keep the Putting Things Right recovery plan and related near miss/low harm reporting under review, with an action for an update in six months. This would allow Quest to escalate any concerns or lack of progress to ARAC as needed, ensuring the issue remains visible and appropriately monitored* **Update 2 March 2026** Trish Mills reported that the position remained as set out in the papers, with no substantive update available at this time. It was agreed this action would remain on the action log and the QuEST committee would be specifically requested to consider the near miss reporting issue as part of its review of the PTR Paper and Recovery plan at the meeting on 7 May 2026 to provide interim assurance to the committee.

5.1 INTERNAL AUDIT PLAN 2026/27

5.1.1 Osian presented the Internal Audit Plan for 2026/27, outlining the risk based approach used to develop the programme, including alignment with the Trust's principal risks, strategic objectives and emerging risks. Osian confirmed that the plan has been developed in consultation with Executive Directors and Audit Wales to ensure appropriate coverage and avoid duplication. The Committee noted that the plan provides a balanced spread of audits across clinical, operational, financial and corporate governance areas and is deliverable within available resources, with flexibility retained to respond to emerging risks during the year.

5.1.2 Chris Turley commented on the absence of a capital audit within the plan, confirming his support for this approach given the limited scope of the current capital programme and the recent audit coverage in this area, while noting that the position would be kept under review should new capital risks emerge.

5.1.3 Judith Bryce and Liz Rogers provided reassurance that wellbeing related risks, including sickness absence and stress management, are being addressed through existing assurance routes and planned internal audits, and that a compliance based audit in these areas would not necessarily provide additional value at this stage. Carl Window welcomed elements of the plan that align with counterfraud risks, noting opportunities for continued collaboration between Internal Audit and Counter Fraud services as audit scopes are developed.

5.1.4 The Chair welcomed the plan and noted that it had been developed through a robust, risk based process, providing appropriate coverage across the organisation with sufficient flexibility to respond to emerging risks during the year.

5.1.5 Members queries regarding the scope of the proposed shift overruns audit, and whether sickness absence should be considered as a separate audit priority, were addressed. Whilst welcoming the breadth of the Internal Audit Plan, Ceri Jackson emphasised the importance of ensuring that the shift overruns audit explicitly considers staff wellbeing impacts alongside reporting accuracy. Members agreed that wellbeing considerations would be incorporated at the planning stage of the shift overruns audit, and it was confirmed that sickness absence would continue to be addressed through the internal deep dive work already scheduled within the IMTP rather than through a separate Internal Audit review.

The committee considered the Internal Audit Plan for 2026/27 and:

1. **Approved the Internal Audit Plan for 2026/27;**
2. **Approved the Internal Audit Mandate and Charter; and**
3. **Noted the associated Internal Audit resource requirements and Key Performance Indicators.**

5.2 INTERNAL AUDIT PROGRESS REPORT

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

5.2.1 Osian Lloyd presented the Internal Audit Progress Report, advising that good progress is being made against the 2025–26 Internal Audit Plan**,** with eight final reports issued, five reports in draft, six audits in progress and one in planning, and no audits yet to commence. Osian confirmed that there are no current concerns regarding delivery of the audit plan**,** and no changes are proposed at this stage.

5.2.2 Osian further reported on the follow-up of audit recommendations**,** noting a 77.6% closure rate for high and medium recommendations due by the reporting date, with validation testing confirming progress, although a small number of actions required further evidence prior to formal closure. Osian highlighted that performance indicators showed two amber ratings, relating to timing of report assurance and management responses, and provided assurance that these reflect specific, understood issues rather than an emerging adverse trend.

5.2.3 The Chair sought clarification on a low completion rate within an earlier audit tracker period, Osian confirmed that this reflected timing issues rather than any cause for concern. Members then questioned the amber rated KPIs, particularly in relation to management responses, Osian advised that delays were attributable to the absence of key individuals rather than indicative of systemic weakness. Trish assured the Committee that strong oversight was in place, including monthly meetings with Internal Audit to address emerging issues, and described the KPI dip as a temporary fluctuation.

5.2.4 Ceri Jackson reflected on the wider challenge of interpreting delays in the context of operational and seasonal pressures, emphasising the need for realistic timescales. Trish noted that the revised tracker approach was already resulting in more achievable deadlines and higher first time closure rates, signalling an improving trajectory.

The committee noted the Internal Audit Progress Report.

5.3 INTERNAL AUDIT REPORTS

5.3.1 **Budget Setting [Reasonable Assurance]**

Felicity Quance highlighted the potential to extend zero based budgeting beyond Digital Services and noted that directorate capacity pressures could affect engagement in future planning cycles. Chris Turley welcomed the report, confirming he was content with the conclusions and management responses, and accepted the proposed actions and timescales.

The Chair also welcomed the report, highlighting the value of the planned thematic review across NHS bodies, while Felicity advised that early benchmarking indicated the Trust was performing strongly in several areas; particularly processes, procedures and engagement, with common challenges identified around training capacity. As such it was noted that the outcome of this audit was on the cusp of being able to provide substantial assurance.

5.3.2 **Clinical Model Transformation Programme [Reasonable Assurance]**

Rachel Marsh welcomed the report, noting that for a programme of this scale the presence of only two medium priority findings placed it close to substantial assurance. Rachel confirmed that the recommendations had been accepted, that actions were being monitored through the CMT Programme Board, and expressed confidence in the programme's governance and delivery.

The Chair noted that, notwithstanding the reasonable assurance rating, the committee could take significant assurance from the quality of governance given the scale and complexity of the programme. Felicity Quance clarified that the reasonable assurance reflected the programme's ongoing, phased nature rather than any fundamental weaknesses and confirmed a high level of understanding, transparency and control.

Ceri Jackson highlighted the strong assurance provided, citing positive staff engagement, training and patient impact, particularly reductions in harm. The Chair agreed reinforced confidence in the programme, with Rachel Marsh reiterating confidence in the arrangements and continued learning approach.

5.3.3 **Cymru High Acuity Response Unit (CHARU) [Reasonable Assurance]**

Andy Swinburn thanked Internal Audit for the review, noting strong engagement and confirming that the findings aligned with issues

already recognised by management and that he agreed with the conclusions and recommendations.

The Chair reflected on the ongoing challenge of benefits realisation amid continuous change and capacity pressures, which Internal Audit acknowledged as a wider system issue requiring a balance of risk, opportunity cost and assurance; Andy Swinburn noted that benefits often materialise over time, making formal evaluation challenging.

Ceri Jackson noted the strong assurance provided, queried improvements in return of spontaneous circulation from cardiac arrest (ROSC) performance data and raised concerns regarding rural and urban clinician exposure. Internal Audit confirmed the data had been validated, and Andy Swinburn advised that differences related to case exposure rather than patient outcomes, with appropriate support arrangements in place for rural clinicians.

The committee took assurance from the reasonable assurance ratings of the Budget Setting; Clinical Model Transformation Programme; and Cymru High Acuity Response Unity (CHARU) Internal Audit Reports.

6. AUDIT WALES

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

6.1 AUDIT COMMITTEE UPDATE

6.1.1 Yvonne Thomas advised that the Independent Examination of the 2024-25 Charity's annual report and accounts had been presented to the Charity Committee in January. Yvonne confirmed that planning work for the 2025/26 accounts audit had commenced, and noted that a detailed audit plan, including identified risks such as management override of controls, would be presented to the committee at its April meeting.

6.2 ANNUAL AUDIT SUMMARY 2025 [including Urgent and Emergency Care Part 3 outcomes]

6.2.1 Fflur Jones presented Audit Wales Annual Audit Summary for 2025, key highlights as follows:

- The fees under the 2026-27 fee scheme include an average increase of 5.3% in the audit of financial statements and performance audit work, which was noted to be above inflation and the Trust's revenue uplift;

- Part three of the Review of Unscheduled Care (national arrangements and leadership structures) will take the form of an article published by Audit Wales rather than a report and will be provided at the earliest opportunity;
- The Review of Digital Transformation has been delayed and will now be presented to the April 2026 meeting. Should it be available prior to the March Finance and Performance Committee it will be presented there first;
- The review of Non-Emergency Patient Transport (with a particular focus on arrangements for transfer and discharge) is in progress and will be presented to the April 2026 meeting; and
- An initial meeting of Audit Wales and Trust colleagues was held at the end of last week to start the review of Estates, which is due to be presented to the September 2026 meeting.

6.2.2 Ceri Jackson asked whether the Urgent and Emergency Care Part 3 work was expected to have significant implications or learning for the Trust. Fflur Jones advised that it wouldn't focus on individual organisations, but would instead provide a system level commentary on national challenges, learning and progress across Wales, drawing together findings from planned and unscheduled care audit work.

6.3 2026 OUTLINE AUDIT PLAN

6.3.1 The committee received and considered the 2026 Outline Audit Plan, which set out Audit Wales' proposed programme of financial and performance audit work for the year, including the associated audit fee.

6.3.2 Chris Turley highlighted the proposed increase in Audit Wales fees, noting the challenging financial context for the Trust and the limited funding uplift available, and commented that additional cost pressures ultimately place strain on already constrained budgets. Ceri Jackson supported this observation, emphasising the cumulative impact of inflationary and audit related cost increases on organisational capacity and risk.

6.3.3 Fflur Jones acknowledged members' concerns and confirmed that Audit Wales operates on a cost recovery basis only, advising that any underspend would be returned to the Trust and that recent fee increases reflect audit quality requirements, workforce changes and inflationary pressures. Fflur further confirmed that the Audit Wales programme has been designed to align with and complement Internal Audit work, with continued engagement planned throughout the year.

6.3.4 The Chair noted the comments raised, recognised the financial pressures highlighted by members, and confirmed that the committee was nevertheless content that the Outline Audit Plan provides appropriate and proportionate audit coverage for 2026.

The committee endorsed the 2026 Outline Audit Plan.

5. AUDIT RISK AND ASSURANCE COMMITTEE 2025/26 QUALITY AND GOVERNANCE REVIEW

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

5.1 Trish Mills presented the Quality and Governance Review, highlighting that the review confirms the committee is operating effectively, with appropriate focus on governance, risk and assurance. Trish noted proposed minor amendments to the committee's terms of reference, primarily relating to attendance arrangements, while confirming that the committee retains the right to request attendance from any Executive Director as required.

5.2 Chris Turley endorsed the review findings and the continuation of the subgroup arrangements, noting that while they require time commitment, they add value by spreading workload across the year and avoiding a single, onerous year-end exercise.

5.3 The Chair welcomed the review and reflected positively on the committee's maturity, balance of challenge and support, and increasing focus on governance effectiveness. The Chair confirmed his support for the continuation of the ARAC subgroup meetings, noting their value in enabling more detailed and reflective discussion outside formal meetings.

5.4 Ceri Jackson supported the findings of the review and the continued use of the National Audit Office (NAO) toolkit. Ceri added that the ARAC subgroup discussions have been constructive and helpful in driving continuous improvement, and will progress development of a refined skills matrix, aligned to organisational priorities and committee responsibility. This work will be brought back to ARAC before being escalated to the Board. Ceri also emphasised the importance of maintaining realism regarding Non Executive capacity and skills coverage and highlighted the value of Board champion roles and targeted development to address any skills gaps.

The committee endorsed the outcomes of the Quality and Governance Review and the changes to its terms of reference; and discussed the committee effectiveness and National Audit Office (NAO) responses, in particular those drawn out at paragraph 5.

6. RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

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

6.1 Julie Boalch presented the Risk Management and Board Assurance Framework (BAF) Report**,** highlighting recent activity and changes to the Trust's principal risks:

- Risk 223 *The Trust's inability to reach patients in the community causing patient harm and death* had been reduced from 25 to 20 following strengthened internal controls, including the implementation of the clinical model, enhanced operational oversight and escalation mechanisms, and confirmed that this change had been agreed by Trust Board;
- 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* remains at 25, pending further consideration of the impact of workforce related risks; and
- Risk 623 *Failure to comply with Data Protection Legislation* had been reduced to target and would now be managed at Directorate level.

6.2 Julie also outlined progress on embedding the Trust's new risk appetite statements, confirming that work is underway to support wider understanding and consistent application across decision making processes. Julie reported on the development of a new electronic enterprise risk management system, which will automate risk capture, improve visibility of controls and enable clearer reporting through a digital Board Assurance Framework. Additionally, Julie described proposals to refine how risk information is presented to the Trust Board, including the introduction of a high level dashboard aligned to principal risks, and the consolidation of detailed scrutiny through committees to ensure more focused and proportionate Board oversight.

6.3 Trish clarified the distinction between the current BAF and the future strategic BAF, noting that the existing version is structured around principal risks and is not yet aligned to strategic objectives. Trish confirmed that, during the transition, the Board will receive focused reporting on key risks (223 and 224) alongside the Avoidable Harm report, with ARAC and other committees continuing to provide full assurance through AAA reports. Trish advised that once the strategic BAF is fully developed and aligned to strategic objectives, it will become a standing Board item.

6.4 The Chair welcomed the report and supported the proposed direction of travel, particularly the move towards more proportionate and focused risk reporting to Board, supported by dashboards and escalation through committee chairs, while recognising that a fully strategic BAF aligned to the new organisational strategy is still under development.

6.5 Ceri Jackson commented positively on the significant progress made in risk management maturity, noting that arrangements are markedly improved compared to earlier years.

6.6 Hayley Hutchings enquired about the impact of the new electronic risk management system. Julie explained that it will replace the Trust's currently fragmented processes with a single, integrated platform, enabling consistent recording, automated escalation, real-time reporting and full activity tracking.

6.7 Julie presented the revised Risk Management Policy, and reported that further refinement is expected as the new digital tools and strategic BAF mature. The revisions presented as part of the policy's update, are as follows:

- incorporate the Board approved risk appetite statements, now included as an annex to the policy;
- ensure clearer articulation of how risk appetite should be used in decision-making, escalation and risk evaluation;
- reflect the Trust's developing approach to embedding risk appetite across committees, directorates and operational governance;
- align terminology and structure with the future electronic enterprise risk management system, ensuring the policy is compatible with the forthcoming digital BAF;
- update procedural descriptions relating to the strategic risk development work**,** including the pilot of Strategic Objective 2; and
- strengthen clarity around responsibilities for risk ownership, oversight and escalation**,** ensuring alignment with the Trust's revised governance arrangements.

6.8 Members welcomed the revisions to the Risk Management Policy and were assured that the inclusion of the Board approved risk appetite statements, alongside clearer responsibilities and alignment with the developing electronic enterprise risk management system, would strengthen consistency and transparency in risk handling across the Trust. The committee endorsed the revised policy for approval by the Trust Board.

The committee:

1. **Considered and endorsed the approach to Board level risk reporting, including:**
   • closer alignment between the current Board Assurance Framework and the Avoidable Harm report; and
   • the proposed frequency for presentation of the full BAF/Corporate Risk Register to the Trust Board.
2. **Endorsed the updated Risk Management Policy for submission to the Trust Board for approval;**
3. **Received assurance on the continued management and oversight of the Trust's principal risks including their review at the Executive Leadership Team and at relevant Committees.**
4. **Noted:**
   a. the changes to principal risk scores including the reduction in Risk 223 from 25 (5x5) to 20 (4x5) and risk 623 from 15 (3x5) to 10 (2x5)
   b. the work being undertaken to align Risks 160 and 558 into one overarching and holistic risk
   c. progress against the 2025/26 Risk Management Work Programme and support the proposed priorities for 2026/27, including the embedding of Risk Appetite, development of a strategic Board Assurance Framework and enhancement of risk reporting arrangements d. the suite of approved Risk Appetite Statements and endorse the next steps for their implementation, monitoring and assurance, as set out in the 2026/27 work programme.

9.1 2025/26 ANNUAL ACCOUNTS UPDATE

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

9.1.1 The committee received an update on progress with the 2025/26 Annual Accounts, including the proposed timetable and arrangements for preparation, audit and approval. Assurance was given planning work is underway, with draft accounts scheduled for completion by the end of April and audited accounts by the end of June, consistent with the previous year's timetable, and that close working is in place between Finance, Governance and Audit Wales to manage risks and dependencies.

9.1.2 The Chair noted and welcomed the consistency of the timetable with prior years and sought assurance that appropriate oversight and escalation arrangements were in place. Members were assured that progress will continue to be monitored closely and that updates will be provided to the committee as the year-end process advances.

9.2 2025/26 ANNUAL FILINGS SCHEDULE

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

9.2.1 The committee received and noted the 2025/26 Annual Filings Schedule, which sets out the timetable for statutory and regulatory returns, including alignment with the annual accounts and annual report deadlines. Assurance was provided that the schedule is consistent with the previous year's timetable and that appropriate governance and escalation arrangements are in place to manage risks and dependencies.

The committee approved the proposed 2026-26 Annual Filings Timetable; received assurance from the planned approach; and noted the planned next steps.

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

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

10.1 Trish Mills presented an update on progress with the Integrated Governance Programme advising that good progress has been made overall, although completion of the Accountability, Assurance and Governance Handbook has been deferred due to capacity pressures, with work expected to recommence in Q1/Q2. Trish emphasised that despite this deferral, a range of practical improvements have been delivered, including updated style guides, templates, "quick read" formats, minute-taking guidance, and improved accessibility of papers. Trish also highlighted the increasing use of digital and AI-enabled tools, including Copilot, to support governance processes and reporting.

10.2 The Chair welcomed the update and noted visible improvements in the quality and clarity of committee papers, endorsing the continued use of digital tools and recognising the need to balance ambition with available capacity.

10.3 Ceri Jackson commented positively on the progress made, particularly improvements in the accessibility and readability of papers, and highlighted the importance of this work given that committee papers are public documents. She supported the direction of travel and the focus on practical, incremental improvement.

The committee received assurance on progress of the integrated governance programme and the 2025/26 deliverables; and noted additional pieces of work that have been developed to further enhance the programme.

11. AUDIT TRACKER 2025-26 Q3 REPORTING (OCT-DEC 25)

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

11.1 Trish Mills introduced the Q3 Audit Tracker update, advising that good overall progress continues to be made across both internal and external audit actions, with a closure rate just under 70**%** and evidence of improved delivery against original target dates. Trish highlighted that a small number of internal audit actions remain on their final revised dates, and confirmed that relevant Executive Directors were present to provide assurance on progress.

11.2 Trish also noted that a new, more intuitive audit tracker format is now in use and that further work is planned to enhance reporting clarity, particularly to support focus on key risks and exceptions. She emphasised the importance of considering not only action closure, but whether actions deliver sustained risk reduction, particularly in relation to the Trust's highest-rated risks.

11.3 Leanne Smith provided assurance on *Audit Action Refs 621b [Technical Resilience] and 692 [ICT Contract Management]*, confirming that strengthened governance arrangements are now in place for high-value and critical digital contracts, with further work underway to extend coverage across remaining contracts and additional actions being monitored through the Finance and Performance Committee.

11.4 Judith Bryce provided assurance on *Audit Action Refs* 053-24/25 and 054-24/25 *[Vehicle Accident Management],* advising that both actions are progressing well following revised timescales, with a pilot checklist and flowchart trial commencing in March, and task-and-finish group work confirming appropriate post-investigation documentation arrangements, with early completion anticipated.

11.5 Liam Williams updated the committee *Audit Action Refs EA/007-EA/011 EA/032-EA/027-EA/031-EA/035 24/25 [Welsh Risk Pool Concerns Asst]* noting that progress has been impacted by capacity pressures linked to PTR recovery and dependencies on forthcoming Listening to People regulations. Liam confirmed that work is progressing on data configuration and reporting, including development of Power BI dashboards, with revised timelines expected to be confirmed by the end of March. Leanne Smith added that foundational data work undertaken for PTR recovery will support more efficient delivery of subsequent audit actions.

11.6 Trish proposed that an action be added for the next ARAC meeting to revisit these timelines, and suggested that, given Liam and Leanne expected to be able to confirm revised dates once the Listening to People Regulations guidance was received and operational capacity stabilised, ARAC should formally check back in at its next meeting to ensure the timelines were clarified and progressing appropriately.

11.7 The Chair agreed, and welcomed the overall progress, noting the improved clarity of reporting, while emphasising the need to maintain focus on the risk impact of delayed actions.

11.8 Ceri Jackson commented that revised dates can appear concerning at headline level, but acknowledged that underlying detail often demonstrates valid dependencies and capacity pressures. Ceri emphasised the importance of realistic timescales and understanding where there is genuine risk versus unavoidable delay.

The committee received assurance on the progress made in closing audit actions during 2025/26 Quarter 3; and noted the audit actions for which final revised dates have been applied in quarter and invite updates from the Directors responsible for these audits.

12. TRUST POLICY REPORT

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

12.1 Trish Mills presented the Trust Policy Report, advising that 56% of policies are currently within date, which is lower than previously anticipated, primarily due to capacity pressures and process complexity. Trish confirmed that governance and oversight arrangements are now well established, with the Policy Group meeting monthly and reporting to the Executive Leadership Team (ELT), enabling prioritisation based on risk and the controlled deferral of lower-risk policies into 2026/27.

12.2 Trish noted that the majority of deferred items relate to policy renewals rather than gaps in control, and that some delays are linked to regulatory dependencies and audit actions. Trish also advised that, in response to a Structured Assessment finding, a Policy Transformation Programme is being developed, with early priorities expected to include simplifying policy templates, improving accessibility, streamlining approval routes, and enhancing guidance and training, with wider reform to be phased as capacity allows.

12.3 The Chair acknowledged the capacity challenges impacting progress and sought assurance that deferred policies would not be subject to the same constraints in 2026/27. Trish confirmed that improved governance oversight, clearer prioritisation through ELT, and planned process simplification are intended to improve delivery next year, with continued focus on higher-risk policies.

12.4 Ceri Jackson raised concern about repeated missed deadlines and stressed the need for realistic timescales and clear assurance on risk, while noting reassurance from ELT oversight. Ceri queried the impact of the stress management policy being out of date in light of the planned internal audit; to which Osian clarified that the audit will assess the Trust's broader approach to staff wellbeing rather than policy compliance alone. Liz Rogers added that stress management is currently supported through existing arrangements, including the All-Wales Managing Attendance at Work policy and stress risk assessments, and confirmed that a stress policy working group is progressing work to finalise the policy and associated digital tools.

12.5 Trish Mills presented the updated Standards of Business Conduct Policy, advising that revisions have been made to reflect the Trust's University Trust status, changes to roles and responsibilities, clearer arrangements for the declaration and handling of gifts and hospitality (including gifts of cash and gifts in kind via the Charity), and amendments to the intellectual property section to remove reliance on an English NHS policy, with no material changes to declarations of interest requirements.

12.6 Carl Kneeshaw highlighted emerging risks associated with secondary employment, including online and social-media-based income streams, and the need for clarity on how such activity should be treated. Trish confirmed that such activity would constitute a declarable financial interest where relevant thresholds are met and advised that further clarity would be considered alongside forthcoming All-Wales social media and intellectual property policies to ensure consistency and appropriate guidance for staff.

The committee:

1. **Noted the progress against the 2025/26 Policy Work Programme (as at 18/02/2026);**
2. **Received assurance regarding the planned approach regarding those policies which remain outstanding, to bring them within review date compliance; and**
3. **Endorsed the updated Standards of Business Conduct Policy for onward submission to Trust Board for approval.**

13. LOSSES AND SPECIAL PAYMENTS
PAYMENTS FOR THE PERIOD FROM 1 APRIL 2025- 31 JANUARY 2026

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

13.1 Chris Turley presented the Losses and Special Payments report, which was submitted for noting in line with standard reporting arrangements. Chris highlighted that the figures reflect cash movements at a point in time and advised that these do not represent the full financial impact, which is managed separately through monthly monitoring and detailed review of provisions, including year-end assessment as part of the annual accounts process.

The committee noted the Losses and Special payment Report for the period 1 April 2025 – 31 January 2026.

14. NON-COMPLIANCE WITH STANDING ORDERS: PUBLICATION OF LATE PAPERS

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

14.1 Trish Mills presented the report on non-compliance with Standing Orders relating to the late publication of papers, noting that this item was included in response to a Structured Assessment recommendation. Trish advised that all instances of late papers had been known and managed exceptions, agreed in advance with the relevant committee or Board Chair, and arose due to specific and legitimate reasons, such as data dependencies, timing of information availability, or urgent matters, rather than failures in planning or governance processes.

14.2 The Chair acknowledged that there can be valid operational reasons for late papers and sought assurance that deadlines were not being missed due to avoidable slippage. Trish confirmed that agendas are tightly commissioned, late papers are actively monitored, and she can account for each instance, with no evidence of systemic issues.

14.3 Ceri Jackson commented on the potential impact of late papers on the quality of scrutiny and assurance, noting that members often rely on scheduled time to review papers in advance, while acknowledging the operational dependencies that can lead to late submissions. Ceri also emphasised the importance of monitoring trends and the degree of lateness to support effective governance. It was agreed that reporting on late papers would be undertaken on a six-monthly basis, with flexibility for earlier reporting on an exception or trend basis should concerns arise.

The committee received and noted the report of non-compliance with standing orders in regard to publication of late papers from 01 January 2026-20 February 2026.

CONSENT ITEMS

15. COMMITTEE PRIORITES AND CYCLE OF BUSINESS MONITORING REPORT 2025/26

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

15.1 Members noted the committee Priorities and Cycle of Business Monitoring Report 2025/26.

CLOSING ITEMS

16. REFLECTIONS

16.1 The committee reflected positively on the effectiveness of the discussion and the quality of assurance provided, noting open and constructive engagement across agenda items. Members highlighted the importance of maintaining a clear line of sight between risk, assurance and delivery, particularly in the current operational context.

16.2 In reflecting on the wider system pressures, the committee acknowledged comments made regarding the financial position, recognising the ongoing challenges and the need for continued vigilance, transparency and alignment between financial sustainability, service priorities and risk management.

16.3 It was noted that, in light of current financial pressures, there is an expectation that attendance at meetings should be proportionate and cost-effective. Members acknowledged that, where appropriate, virtual attendance should be the default to support financial sustainability, with in-person attendance reserved for circumstances where it adds clear value.

17. ANY OTHER BUSINESS

17.1 There was no other business discussed.

18. DATE OF THE NEXT MEETING

18.1 28 April 2026.

MEETING CLOSE: 13:15

ACTION LOG
WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST - AUDIT, RISK AND ASSURANCE COMMITTEE

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
14.2/02092025	2 September 2025	**Assurance to ARAC on Near Miss and Low Harm Intelligence Framework**	Trish Mills suggested that, instead of scheduling a fixed six-month report to ARAC, the committee should use the AAA (alert, advise, assure) process to formally request Quest to keep the Putting Things Right recovery plan and related near miss/low harm reporting under review, with an action for an update in six months. This would allow Quest to escalate any concerns or lack of progress to ARAC as needed, ensuring the issue remains visible and appropriately monitored	Trish Mills	7 May 2026	**Update 2 March 2026** Trish Mills Mills reported that the position remained as set out in the papers, with no substantive update available at this time. It was agreed this action would remain on the action log and the QuEST committee would be specifically requested to consder the near miss reporting issue as part of its review of the PTR Paper and Recovery Plan at the meeting on **7 May 2026** to provide interim assurance to the committee. **Update 18 February 2026** The focus has been on the PTR Recovery Plan with little movement in near miss reporting, however it is anticipated that once recovered this position will improve. A verbal update will be provided at the meeting 2 March 2026. **Update 12 December 2025** Following the ASM, it was confirmed this will be updated through the Action Log following the meeting of QuEST to provide an update on the position. **Update 2 December 2025 from Trish Mills** Trish Mills reported that she will bring an update to the March 2026 meeting, there are no expected changes until then. **Update 4 November 2025** The QuEST Committee received a AAA from ARAC regarding Near Miss and Low Harm Intelligence Reporting.	Not Due
11.7/02032026	2 March 2026	**Audit Tracker 2025-26 Q3 Reporting (Oct-Dec 25) Welsh Risk Pool**	It was agreed that a further update would be brought to the next Audit, Risk and Assurance Committee meeting to confirm revised timelines for the remaining outstanding audit actions relating to Welsh Risk Pool (WRP), once dependencies and national guidance have been clarified.	Trish Mills	28 April 2026	**Update from Lisa Trounce 20 April 2026** A number of WRP actions have been closed in quarter and those due, but not yet completed, will need to have revised dates applied.	Complete
14.3/02022026	2 March 2026	**Non-Compliance with Standing Orders: Publication of Late Papers**	It was agreed that reporting on late papers would be undertaken on a six monthly basis, with flexibility for earlier reporting on an exception or trend basis should concerns arise.	Trish Mills	3 September 2026		Not Due

AUDIT, RISK AND ASSURANCE COMMITTEE HIGHLIGHT REPORT TO BOARD

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

Trust Board Meeting Date	26 March 2026
Committee Meeting Date	2 March 2026
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. The Committee noted that several corporate functions continue to experience significant pressure. While there remains a strong ambition to progress transformation activity and to build on solid progress achieved to date, the **challenging financial environment** anticipated for 2026–27 means that a 'best endeavours within available resources' approach will be required across several areas. Members recognised that, although high-risk assurance activities will be prioritised, it may not be possible to sustain gold- or platinum-level maturity across some areas of corporate services. The Committee highlighted the importance of ongoing oversight of these pressures and agreed to escalate this to the board to set realistic expectations and signal that the organisation is entering a period that will require careful prioritisation and balanced risk management. This is an issue for Trust Board and all Committees (including ARAC) to be cognisant of.

ADVISE

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

2. A **pre-meeting** was held with Audit Wales, Internal Audit and the committee Chair ahead of the meeting.
3. The **2026/27 Internal Audit Plan** was approved by the committee. The plan is linked to the Trust's principal risks and is set out below. The plan does not include a capital management audit given the scope of the capital programme with the fleet replacement programme being by far the biggest element and this being subject to a current audit ongoing. The position will be kept under review if new or significant capital schemes emerge. The plan includes:

   - Risk Management & Board Assurance
   - Follow up Report
   - Savings Planning and Monitoring Arrangements
   - Integrated Medium-Term Plan Delivery

- Commercial Development & Income Generation
- Family Complaints – Putting Things Right & Legal Services Recovery Plan
- Medical Examiner System & Mortality Reviews
- Clinical Navigator Role – Effectiveness and Integration
- Shift Overruns
- Time off in Lieu
- Medical Gases
- Cyber Security
- Shadow IT
- Service Management
- Secondary Employment: Disclosure and Control Arrangements
- Anti-Sexual Harassment Policy & Implementation Plan
- Stress Management
- Estates Assurance: Control of Contractors

4. Members **reflected** positively on the quality of discussion and flow of the meeting. It was noted that the agenda had been well-structured, the discussion had been constructive and appropriately detailed, and the level of assurance received across items was strong, albeit showing some challenges. Members commented that the papers were clear and helpful, and that the meeting supported effective scrutiny and understanding of key risks and governance matters. Those newer to the committee also reflected that the discussions provided valuable insight into the committee's role and the wider assurance framework.
5. The **Risk Management Policy** and the **Standards of Business Conduct Policy** were endorsed by committee. Changes to the Risk Management Policy include the addition of the Trust's risk appetite statements, and there were minor adjustments to the Standards of Business Policy. Both are recommended for approval.

ASSURE

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

6. **Audit** Wales updated the committee on progress and provided their annual audit summary for 2025, including:

   - The fees under the 2026-27 fee scheme include an average increase of 5.3% in the audit of financial statements and performance audit work, which was noted to be above inflation and the Trust's revenue uplift.

   - Part three of the Review of Unscheduled Care (national arrangements and leadership structures) will take the form of an article published by Audit Wales rather than a report and will be provided at the earliest opportunity.

   - The Review of Digital Transformation has been delayed and will now be presented to the April 2026 meeting. Should it be available prior to the March Finance and Performance Committee it will be presented there first.

- The review of Non-Emergency Patient Transport (with a particular focus on arrangements for transfer and discharge) is in progress and will be presented to the April 2026 meeting.

- An initial meeting of Audit Wales and Trust colleagues was held at the end of last week to start the review of Estates, which is due to be presented to the September 2026 meeting.

7. **Internal Audit** reported steady progress against the 2025/26 plan noting a slight delay in audits reported over planned (11 out of 13) and management responses within 15 days (5 out of 7), however there is confidence that the audit plan will be completed by June. Members emphasised the importance of balancing delivery of audit recommendations with competing priorities, recognising that delays often reflect workforce constraints rather than lack of progress. Internal audit and management confirmed that improved realism in timelines and regular monitoring are helping to strengthen grip despite these pressures.

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

   - **Budget Setting – Reasonable Assurance**. This audit reviewed how the Trust allocates resources to meet its agreed budget. As the review is being undertaken across five NHS Wales organisations, it will enable comparison of financial planning and budget setting arrangements and the identification of common themes and good practice.

     Members supported the conclusions of the audit and noted the strength of the organisation's financial management, including the consistent delivery of balanced budgets and stable performance in the year. The Committee highlighted the disciplined approach to budgeting, the close alignment between budgets and actuals, and the positive findings from the thematic review across NHS bodies. Members sought clarification on the proximity to achieving substantial assurance and noted internal audit's confirmation that the Trust was at the upper end of reasonable assurance, with three medium priority findings preventing a higher rating.

     The Finance and Performance Committee will review this alongside the usual financial reporting at its March meeting.

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

     The committee noted the scale and complexity of the Clinical Model Transformation Programme and was assured that strong governance arrangements, clear programme structures and effective oversight were in place. It was confirmed that actions arising from the audit were being monitored through the Programme Board, with the majority progressing as planned.

The committee welcomed the positive audit findings, recognising the clear ambition of the programme and the early benefits emerging through staff engagement and improved patient outcomes. The committee further acknowledged that the reasonable assurance rating reflected the ongoing and evolving nature of the programme rather than any concerns regarding robustness or management.

The Finance and Performance Committee will review this alongside the usual IMTP reporting at its March meeting.

- **Cymru High Acuity Response Unit (CHARU) – Reasonable Assurance**. This audit reviewed the effectiveness of CHARU in delivering improvements to patient care.

  The committee welcomed the audit findings and noted agreement with the recommendations, recognising that the report provided a clear direction for strengthening training oversight, governance representation and benefits realisation.

  Members discussed the wider challenge of evaluating benefits within fast-moving change programmes, acknowledging the importance of maintaining discipline in measuring impact. It was noted that this is a common issue across NHS Wales, with new clinical indicators beginning to offer improved intelligence to support evaluation.

  The committee sought clarification on the data improvements underpinning higher ROSC (return of spontaneous circulation) rates and noted that the key factor related to clinicians' exposure to relevant cases rather than differences in patient outcomes, highlighting the need for tailored support in rural areas.

  The Quality, Patient Experience and Safety Committee will review this alongside a review of the Return of Spontaneous Circulation (ROSC) clinical indicator at its March meeting.

9. Members were assured of arrangements for the development of the **2025-26 audit of the financial accounts and the 2025-26 annual report**.

10. The **Integrated Governance Programme** is progressing well; however, completion of the accountability and assurance handbook has slowed and will pick up again in Q1 2026/27. Several initiatives were noted for improving efficiency and effectiveness at board and internal governance forums.

11. The Committee received an update on progress with the trust's **policy programme** and noted that 56% of policies are currently in date. Concerns were raised as to the risks this poses as it is outside the trajectory set for 2025/26 of c.85%. While several policies have been deferred into 2026/27 the majority of them were extant policies, with delays primarily due to capacity constraints and interdependencies. Members were assured that governance arrangements around policy oversight remain strong. Work is underway to establish a policy transformation programme in response to the structured assessment recommendation, focusing initially on simplifying the policy template, improving the end to end process and refining approval routes.

12. The **losses and special payments** were reviewed for the period from 01 April – 31 January 2026 and noted as being -£1.797 million. This relates to actual payments made, less the reimbursements received from the Welsh Risk Pool and does not relate to any adjustments made to the provision and the resulting full in year costs charged and accrued.

13. The committee reviewed the **Q3 2025/26 Audit Tracker** and were assured that a positive audit culture is developing, with more audits closed on their original date, reflecting more realistic timelines. Directors and deputies confirmed that audit actions on their final deadlines are achievable and that associated risks are not increasing.

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

15. **In private session** the Committee received the local counter fraud update, tender update and single tender awards, and two risks and associated audit actions. There are no escalations to the board.

RISKS

16. A revised approach to board level risk reporting was endorsed to strengthen alignment with the current Board Assurance Framework (BAF) and the board's Avoidable Harm Report during the interim period. Assurance and escalation relating to principal risks will continue to be provided through committee AAAs, supported by an appended dashboard highlighting any material changes. This approach will remain in place while the new strategic BAF is developed, embedded and incorporating reporting on the effective management and delivery of the Trust's strategic objectives.

17. Members were assured in respect of the Trust's principal risk activity noting the reduction in Risk 223, reflecting the strength of internal controls, and the ongoing management of Risk 623 at a directorate level given this reached its target score of 10. In private session, Members received assurance on the details of Risk 620 and Risk 260 noting that there were no material changes during this period.

18. Members welcomed the progress of the risk management work programme to date and supported the direction of travel for 2026/27.

COMMITTEE AGENDA FOR MEETING IN DECEMBER 2025		
Internal Audit: - 2026/27 internal audit plan - Progress report - Budget setting audit report - CMT audit report - CHARU audit report	Audit Wales: - Update report - Annual audit summary 2025 - 2026 Outline audit plan	ARAC quality governance reviews 2025/26
Risk Management and BAF	Integrated governance programme progress update	Audit tracker Q3
Policy report Standards of Business Conduct Policy	Losses and special payments report	Standing orders compliance report – publication of late papers.
Cycle of business and committee priorities		

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

Key	
(green)	Attended
(amber)	Deputy attended
(red)	Apologies received
(black)	No longer member

[1] The chairs of the Finance and Performance Committee (Jayne Beeslee) and QUEST (Bethan Evans) were in attendance for the committee effectiveness reviews
[2] Jason Killens, CEO, joined for the presentation and endorsement of the annual report and audited accounts
[3] Emma Wood, CEO joined this meeting

Agenda Item No.	05

REPORT TITLE

2025/26 Quality Governance Reviews

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	28 April 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The Trust has completed its 2025/26 programme of quality and governance reviews across board committees, in line with the annual assurance cycle. All committee reviews have been concluded, except for the Welsh Ambulance Services Partnership Team (WASPT) review, which has been formally deferred to June 2026.

2. All the committee annual reports are presented to the Audit, Risk and Assurance Committee (ARAC) for endorsement ahead of submission to Trust Board in May 2026. The qualitative review approach adopted this year, following a more extensive review in 2024/25, has not identified any matters requiring escalation which have not already been considered by the ARAC and board, and provides assurance on the effectiveness of committee operation and governance arrangements.

3. This assurance activity has taken place alongside a broader programme of governance development, including an externally commissioned effectiveness review by the Good Governance Institute. To ensure changes are proportionate, the board has agreed to a phased approach to implementation, with limited agreed adjustments taking effect from 1 April 2026 and more substantive structural changes deferred pending receipt of the external review findings.

4. In parallel, ARAC has completed its own annual effectiveness review using the National Audit Office (NAO) toolkit, identifying further actions relating to communication and skills development, which are being progressed during 2026/27. The ARAC 2025/26 annual report is here for consideration with the revised 2026/27 cycle of business.

5. Taken together, this work provides assurance that the board committee framework remains effective, while positioning the Trust to respond appropriately to emerging governance insights and future improvement opportunities.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The committee is requested to:

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

ADDITIONAL PAPER(S)

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

1. The committee is asked to receive:
   Annex 1: Academic Partnership Committee (APC) 2025/26 annual report
   Annex 2: Charity Committee (CC) 2025/26 annual report
   Annex 3: Finance and Performance Committee (FPC) 2025/26 annual report
   Annex 4: People and Culture Committee (PCC) 2025/26 annual report
   Annex 5: Quality, Patient Experience and Safety Committee (QuESt) 2025/26 annual report
   Annex 6: Remuneration Committee (RemCom) 2025/26 annual report
   Annex 7: ARAC 2025/26 annual report
   Annex 8: ARAC 26/27 cycle of business

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
16 July and 24 September	ELT discussions on 2025-26 reviews
25 July and 30 September	ARAC Sub-Group discussions on 2025-26 reviews
2 September 2025	ARAC update on quality and governance review
7 October 2025	APC meeting re quality and governance review
4 November 2025	QuEST meeting re quality and governance review
13 November 2025	PCC meeting re quality and governance review
18 November 2025	FPC meeting re quality and governance review
2 December 2025	ARAC meeting
29 January 2026	Trust Board meeting
2 March 2026	ARAC meeting

SITUATION

1. The Trust has completed its 2025/26 programme of quality and governance reviews across board committees, consistent with the annual assurance cycle. All committee reviews have been concluded, except for the Welsh Ambulance Services Partnership Team (WASPT), where the review has been formally deferred to June 2026. This has enabled the preparation of draft committee annual reports and updated cycles of business, which are being presented through the Audit, Risk and Assurance Committee (ARAC) for endorsement ahead of submission to Trust Board in May.

2. The review activity has taken place alongside a broader period of governance development, including Trust Board–approved adjustments to the committee framework and an externally commissioned effectiveness review led by the Good Governance Institute. As a result, while the committee annual reports and associated routine updates are progressing as planned, some structural changes to committee configuration and remit are being phased, with material changes intentionally deferred pending receipt of the external review findings.

3. Following this work throughout 2025/26 the ARAC can be assured of the effectiveness of the board committee framework, noting that there are further changes which will be implemented – potentially in 2026/27. Additionally, as part of the integrated governance programme in 2026, the Trust will refresh the governance framework and the structures to which the executive delegates work. This will strengthen the operation of assurance from floor to board, supporting clear visibility of performance and risk to the Accountable Officer and the board.

BACKGROUND

4. Following the comprehensive committee effectiveness review undertaken in 2024/25, ARAC agreed that the 2025/26 quality and governance reviews would adopt a proportionate, qualitative approach. Committees were invited to provide feedback through a short survey of members and prescribed attendees, focusing on terms of reference, membership, what is working well, and opportunities for improvement.

5. In January 2026, the Trust Board approved proposed adjustments to the committee framework, while also commissioning an external effectiveness review by the Good Governance Institute to assess the appropriateness of committee number, scope and focus. To avoid premature or duplicative change, ARAC recommended a phased implementation approach, with limited agreed adjustments taking effect from 1 April 2026 and more substantive changes

deferred pending receipt of the external review findings. In parallel, ARAC has completed its own annual review using the National Audit Office effectiveness toolkit, identifying further actions relating to communication and skills development, which are being progressed through the ARAC sub-group and will inform future board-level governance work.

ASSESSMENT

2025/26 Quality and Governance Reviews for Committees

6. Given the extensive review undertaken in 2024/25, ARAC agreed that this year's approach would be qualitative. This included a survey of members to gather feedback on the proposed changes to the terms of reference (including membership) and to identify what is working well and where improvements could be made. The following four questions were asked of committee members and prescribed attendees:

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

7. Engagement with the surveys was not high; however, a good deal of qualitative information was obtained. There is nothing to escalate from any of the committees in the responses.

8. Following the completion of this annual activity the suite of board committee annual reports are before the ARAC for endorsement before presentation to board in May. The associated changes to the terms of reference for the board committees (except WASPT) have already been approved by the Trust Board. The annual reports of each committee are attached as follows:

   8.1. Annex 1: Academic Partnership Committee (APC)
   8.2. Annex 2: Charity Committee (CC)
   8.3. Annex 3: Finance and Performance Committee (FPC)
   8.4. Annex 4: People and Culture Committee (PCC)
   8.5. Annex 5: Quality, Patient Experience and Safety Committee (QuESt)
   8.6. Annex 6: Remuneration Committee (RemCom)

9. The below sets out the feedback from each committee from their 2025/26 review:

Committee	Survey feedback
Academic Partnership Committee	The APC met on the 7 October 2025 and considered the 2025/26 quality governance review, endorsing the position proposed by the ARAC to redistribute the committee's current responsibilities as follows: • Research: To be transferred to the Finance and Performance Committee (FPC), aligning with Strategic Objective three and enabling integration with technology, commercialisation, and financial sustainability portfolios. • Partnerships: Education and training collaborations to move to the People and Culture Committee (PCC), while commercial partnerships will be overseen by FPC. • University Trust Status (UTS): UTS is a designation, not a standalone programme. Oversight should focus on the contributing activities which are to be aggregated and monitored through the IMTP, with FPC ensuring visibility. It was recommended that the APC continue to meet in 2026/27 for oversight of the research portfolio, with its other responsibilities related to education and training partnerships and collaboration transferring to the PCC, and commercial partnerships transitioning to the FPC from 1 April 2026.
Charity Committee	Members were content with the current terms of reference, and most felt the committee's membership remained appropriate; though some suggested considering involvement from project leads for emerging areas of charity work such as volunteering, staff wellbeing, or the Wish Ambulance as new strategic projects progress. The committee felt there was strong engagement from members and commended the quality of papers. Some improvements were suggested which focused on strengthening pre-committee governance structures to streamline operational discussions, and enabling a clearer focus on strategic priorities, alongside a call to further accelerate the Charity's ambition.
Finance and Performance Committee	Members praised the committee's well-structured agendas, strong chairing, high-quality reporting, constructive scrutiny, transparent engagement from the Executive Leadership Team, and excellent corporate governance support.

Committee	Survey feedback
	Suggested improvements centred largely on supporting members with complex or less-familiar areas of business, including potential bespoke development on fleet, estates and environmental matters; as well as continued work to improve the clarity and succinctness of reports. Further recommendations included ensuring consistency in how key metrics are reported across committees, reducing duplication between committees, maintaining regular reviews of potential remit overlaps and conflicts of interest, and continuing to refine the quality and volume of committee papers through ongoing writing-guidance improvements.
People and Culture Committee	Members felt that the committee is valued for its inclusivity, active participation, and high-quality reporting, which foster a collaborative environment and effective assurance to the board. There is a desire for the committee to focus more on strategic priorities and to measure the tangible impact of its work, ensuring that discussions address the most pressing and relevant issues for staff and the organisation.
Quality, Patient Experience and Safety Committee	Members felt that the committee's membership is appropriate and diverse, and whilst concerns were raised about the number of attendees, with some questioning the value added by non-contributing participants, wide attendance is encouraged and welcomed by the committee in open session.
Remuneration Committee	Members felt that the committee was functioning effectively, with clear, focused agendas; succinct and well-presented papers; strong attendance and engagement; and constructive, open discussion supported by good governance and executive input. Members confirmed no changes were needed to the terms of reference or membership for 2026/27, though some queried the rationale for full NED membership and the quorum of three, both of which reflect established NHS best practice and wider Board expectations.

Non-compliance with Standing Orders

10. The Trust standing orders require that the board committees present the end of year annual reports to the board within six weeks of the end of the financial year. Due to the timing of the board meetings this timeframe will not be met. The ARAC must be notified of this non-compliance with standing orders. All reports except for the WASPT have been completed, and the respective AAAs have reported to the board the completion of this work and escalated any issues to the board, as required.

11. The reason that the report for WASPT has not been completed is because the group asked for the survey to be extended to permit further engagement from members. The annual quality and governance review work is therefore not complete. The business was originally programme for receipt in April 2026 but deferred to the June 2026 WASPT. The outcomes/annual report will be reported to the board in July 2026, which significantly exceeds the six-week timeframe.

The Board's Committee Framework and Good Governance Institute Review

12. In 2025 the board engaged the Good Governance Institute to undertake a board effectiveness review. That programme will review whether the current number and scope of committees are right for an organisation of Trust's size and complexity. It will also look at whether the board's focus, timing, and balance between strategy, performance, risk management, and culture are appropriate.

13. This external review forms the board's 2025/26 quality and governance review, and the outputs and recommendations will be presented to the board in May 2026.

14. As indicated to this committee and the board on a number of occasions, the findings from this review are likely to influence both the remit and meeting frequency of some committees.

Quality and Governance Review for ARAC

15. ARAC undertakes its annual quality and governance review in line with the NAO effectiveness toolkit. The ARAC received the output of the 2025/26 toolkit at its meeting on the 2 March 2026, and their 2026/27 terms of reference were approved.

16. The ARAC 2025/26 annual report is presented here for review and endorsement, with the 2026/27 cycle of business for approval.

17. At the 2 March 2026 ARAC there were actions agreed in response to the 2025/26 review of the NAO effectiveness toolkit. These actions were in relation to communication between key ARAC stakeholders and the skills and experience of members. These matters will be taken to the ARAC sub-group for progression.

RECOMMENDATION

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

NEXT STEPS

19. The ARAC sub-group will be convened to progress the ARAC specific developmental requirements as identified from the 2025/26 by quarter two.

20. The outcome report from the Good Governance Institute will be reviewed by the board and the associated programme of work developed for progression.

ACADEMIC PARTNERSHIP COMMITTEE ANNUAL REPORT 2025/26

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, committee terms of reference, and codes of governance provide that boards should routinely assess the effectiveness of their governance arrangements, of which the board's committees form an integral part.

4. The Academic Partnership Committee (APC) met on 7 October 2025 and, through a facilitated discussion, considered the board committee 2025/26 quality governance review, endorsing the position proposed by the Audit, Risk and Assurance Committee. The outcomes of the discussion on 7 October are described within this report. This Annual Report reflects on the effectiveness of the committee in 2025/26 and proposes changes to its terms of reference.

5. The Trust Board has commissioned an external effectiveness review which will be undertaken in early 2026 by the Good Governance Institute (GGI). The GGI will review the board committee framework within quarter four 2025/26 and quarter one of 2026/27 which may necessitate further changes throughout 2026/27. Although at this stage it is not anticipated that there will be material changes to this committee.

PURPOSE OF THE COMMITTEE

6. The purpose of the Committee as set out in the 2024/25 terms of reference reflected the maturing University Trust Status (UTS) journey. The committee approached its remit with a mixture of *scrutiny* (particularly with respect to refreshed UTS priorities, obtaining and maintaining UTS status), *partnering* (ensuring the right partners were on the Committee, that appropriate arrangements were in place with partners), *connecting* (existing and new partners to research/programmes of work in WAST), and *inquisitorial* (drilling down into elements of the priorities and other programmes where we are partnering with academic and industry to foster and promote).

7. However, the committee's focus in 2025/26 was solely on the areas delegated from the board in relation to research and oversight of the Trust's research governance framework. This reflects the evolution of the Trust's governance for other committee responsibilities and the achievement of University Trust Status, which was the original purpose of the committee's establishment. Academic partnerships and research are now embedded across multiple areas of the Trust's strategy and planning processes, meaning that the committee's agendas had become less predictable and its business was naturally drawing to a close.

MEMBERSHIP AND ATTENDANCE

8. In light of this position, it was only necessary for the committee to meet twice in 2025/26 (and was quorate on each occasion). There were four meetings scheduled throughout 2025/26; however, its Members agreed to stand down two of the meetings for the reasons set out in paragraph seven. The committee met in October 2025 and March 2026, respectively.

9. The committee has been supported by the Chair and two Non-Executive Directors as members, and a number of prescribed attendees with good attendance. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2025/26.

COMMITTEE ATTENDANCE				
Name	07 October 2025	06 March 2026		
Hannah Rowan				
Prof Hayley Hutchings				
Jayne Beeslee				
Estelle Hitchon				
Carl Kneeshaw				
Andy Swinburn				
Jonny Sammut	Keith Dorrington	Keith Dorrington		
Jonathan Chippendale				
Prof Nigel Rees				
James Houston				
Jo Kelso				
Trish Mills	Julie Boalch	Julie Boalch		
Mark Marsden				
Keith Rogers				
Ceri Griffiths				

	Attended
	Deputy attended
	Apologies received
	No longer member

10. There has been one adjustment to the membership in year reflecting the restructure within the Quality, Safety and Patient Experience directorate. The role of the 'Assistant Director of Quality and Nursing' has been superseded by the role of 'Deputy Director of Remote Clinical Care.'

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

11. During 2024/25 the ARAC initiated a project to streamline the Trust's governance structures. Key drivers included Non-Executive Director availability, quorum pressures, the high volume of meetings and the transitional status of this committee following the achievement of University Trust Status.

12. The ARAC project group considered a range of options, which culminated in a preferred option to reduce the number of board committees from seven to six by standing down the APC subject to Board approval.

13. The APC met on the 7 October 2025 and considered the 2025/26 quality governance review, endorsing the position proposed by the ARAC to redistribute the committee's current responsibilities as follows:
    13.1. *Research:* To be transferred to the Finance and Performance Committee (FPC), aligning with Strategic Objective three and enabling integration with technology, commercialisation, and financial sustainability portfolios.

13.2. *Partnerships:* Education and training collaborations to move to the People and Culture Committee (PCC), while commercial partnerships will be overseen by FPC.

13.3. *University Trust Status (UTS):* UTS is a designation, not a standalone programme. Oversight should focus on the contributing activities which are to be aggregated and monitored through the IMTP, with FPC ensuring visibility.

14. It was recommended that the APC continue to meet in 2026/27 for oversight of the research portfolio, with its other responsibilities related to education and training partnerships and collaboration transferring to the PCC, and commercial partnerships transitioning to the FPC from 1 April 2026.

15. The direct link to the paper setting out the position is available here: ambulance.nhs.wales/files/committee-meetings/academic-partnership-committee/papers-7-october-2025/.

Management of the committee's work programme

16. The committee has a cycle of business that is aligned to its terms of reference. A cycle of business for 2025/26 was not prepared due to the changes to the committee's remit; however, due to the ongoing discussions regarding the board committee framework and the position reached in year (as discussed on the 7 October), the business transacted was deliberately limited to matters regarding research and the research governance framework.

17. The board is kept informed of the committee's oversight of a range of issues by way of an 'Alert,' 'Assure' and 'Advise' (AAA) report to the Board after each meeting. Any issues of concern are escalated to the board in the 'Alert' section, and the chair of this committee presents that report at each board meeting.

18. Other than that which is set out in this report, the substantial detail of the work of the committee in 2025/26 is included in the committee AAA reports which are linked below:

18.1. AAA: 7 October 2025
18.2. AAA: 6 March 2026

19. The committee is required to promote and support the exploration of opportunities with higher and further education providers, commercial partners, and wider community partners for collaboration. The purpose of these sections 3.1 to 3.3 in the terms of reference and the way in which the committee discharges these were explored in the January meeting.

20. The board received a highlight report from this committee by email circulation following each meeting which included alerts, advice, and areas of assurance. This was also presented to the next public board meeting by the Chair of the committee.

21. All committee papers were published in line with the Trust's Board and Committees Secretariat Standard Operating Procedure.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

22. The changes to the terms of reference for 2026/27 reflect those proposed by the ARAC and as endorsed by the committee on the 7 October 2025. The two areas delegated by the board, which remain in the committee's terms of reference, are to:

    22.1. Oversee the strategic direction and development of research and innovation activities within the Trust, and to oversee the implementation of the research governance framework in accordance with the Health and Care Research Wales Research Governance Framework,' and
    22.2. Monitor plans to build capacity for the whole workforce whether they be in a clinical, professional, or corporate role, to participate in research; that opportunities to do so are being promoted; and that the workforce is encouraged to be professionally inquisitive.

23. The remaining changes to the terms of reference align them with updates made to other committee terms of reference and reflect adjustments to membership based on the revised remit. This is partly because the terms of reference were not amended for 2025/26, unlike those of the other committees.

COMMITTEE PRIORITIES

Priorities for 2025/26

24. The committee did not set priorities for the 2025/26 due to the ongoing discussions regarding the board committee framework and its future role and remit.

Priorities for 2026/27

25. It is good practice for committees to set priorities for the forthcoming year when they review their effectiveness. However, given the agreed position regarding the committee and the changes to the terms of reference for 2026/27 it has been considered unnecessary to set priorities for the forthcoming year.

CHARITY COMMITTEE
ANNUAL REPORT 2025/26

INTRODUCTION

1. The Trust's Standing Orders and this committee's terms of reference requires that board committees evaluate their effectiveness annually and present an annual report to the Trust Board/Corporate Trustee.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of committees ensure governance remains fit for purpose.

3. Standing Orders, committee terms of reference, and codes of governance provide that boards should routinely assess the effectiveness of their governance arrangements, of which this committee forms an integral part.

4. The committee met on 13 January 2026 and 2 April 2026 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2025/26 and proposes changes to terms of reference.

5. The Trust Board has commissioned an external effectiveness review which commenced in early 2026 by the Good Governance Institute (GGI). The GGI will be reviewing the board committee framework within quarter four 2025/26 and quarter one of 2026/27 which may necessitate further changes throughout 2026/27. Although at this stage it is not anticipated that there will be material changes to this committee.

PURPOSE OF THE COMMITTEE

6. The purpose of the committee as set out in its terms of reference is to:

   - Contribute to the development of the charity's strategy and monitor is implementation.
   - Assure the Corporate Trustee that charitable funds are accounted for, deployed, and invested in line with legal and statutory requirements, taking account of the public benefit guidance.
   - Consider and endorse the annual report and accounts for approval by the Corporate Trustees; and
   - Raise the profile and reputation of the charity within the Trust.

MEMBERSHIP AND ATTENDANCE

7. The committee met four times as scheduled in 2025/26, was well attended and quorate on each occasion.

8. The committee is supported by the Chair and two Non-Executive Directors. The Director of Partnerships and Engagement is the executive lead, and the Executive Director of Finance and Corporate Resources is the Charity Treasurer. Attendance in 2025/26 was excellent. The chart below illustrates the attendance of members and attendees as listed in the terms of reference, and in addition, the committee welcomed guests and observers at various meetings.

COMMITTEE ATTENDANCE				
Name	**2 April 2025**	**3 July 2025**	**2 October 2025**	**13 January 2025**
Peter Curran (Chair)				
Ceri Jackson				
Hannah Rowan				
Estelle Hitchon				
Chris Turley			Ed Roberts	
Lee Brooks		Mark Harris		From item 7 to 13
Andy Swinburn				
Liz Rogers	From Finance Item		Sara Williams	
Trish Mills				
Hugh Parry			Left meeting at 09:30	
Damon Turner			Left meeting at 09:30	
Marcus Viggers	From Performance Item		Left meeting at 09:30	
Julie Boalch				
Jo Kelso				
David Hopkins				
Leanne Smith			Attended for item 11	
Jackie Hatton-Bell				
Andrew Cotton				
Matt Dugdale				

Key	
	Attended
	Deputy attended
	Apologies received
	No longer member/not member

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

9. The committee undertook a light effectiveness review on 13 January 2026, as agreed with the Audit, Risk and Assurance Committee (ARAC). This was due to the comprehensive review undertaken in 2024/25 involving a detailed examination of the terms of reference and the assurance arrangements for each delegated responsibility. No changes have been proposed to the terms of reference for 2026/27 except for the removal of the Executive Director of Paramedicine as a prescribed attendee.

10. For the 2025/26 effectiveness review, a survey of the members was carried out to gather feedback on the proposed changes to the terms of references and to identify what is working well, and where improvements could be made. The questions asked were:

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

11. The feedback from the committee concluded that members were content with the current terms of reference, and most felt the committee's membership remained appropriate; though some suggested considering involvement from project leads for emerging areas of charity work such as volunteering, staff wellbeing, or the Wish Ambulance as new strategic projects progress. The committee felt there was strong engagement from members and commended the quality of papers. Some improvements were suggested which focused on strengthening pre-committee governance structures to streamline operational discussions, and enabling a clearer focus on strategic priorities, alongside a call to further accelerate the Charity's ambition.

Management of the committee's work programme

12. The committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the committee and in this respect, it has discharged its responsibilities in providing assurance to the board and also to the Corporate Trustee. To ensure real-time effectiveness at each meeting the committee receives a monitoring report against the cycle of business which escalates matters for the attention of the committee.

13. The Corporate Trustee is kept informed of the committee's oversight of a range of issues by way of an 'Alert', 'Assure' and 'Advise' (AAA) report after each meeting. Any issues of concern are escalated to in the 'Alert' section, and the Chair of this committee presents that report at each corporate trustee meeting.

14. Other than that which is set out in this report, the substantial detail of the work of the committee in 2025/26 is included in the committee AAA reports which are linked below:

    14.1. AAA: 2 April 2025
    14.2. AAA: 3 July 2025
    14.3. AAA: 2 October 2025
    14.4. AAA: 13 January 2026

15. In year, all papers were published in line with the Trust's Board and Committees Secretariat Standard Operating Procedure except the fundraising targets and expenditure paper in April 2025, and the risk report and Bids and Bursary panel AAAs in October 2025.

SUB-COMMITTEES AND TASK AND FINISH GROUPS

16. The Bids Panel and Bursary Panel are the established sub-committees of the committee. As set out above, they report to the committee by way of a AAA report and the committee in turn reports to the corporate trustee on their work. The Bids Panel has an authority level of £5k and Bursary Panel of £3k.

17. Both panels demonstrate the application of the Healthcare Financial Management Association (HFMA) guidance on the use of NHS Charitable Funds.

18. The Bids Panel held seven meetings in 2025/26 (three of which were extraordinary meetings). The Bursary Panel met twice in 2025/26.

19. The terms of reference of both the Bids and Bursary Panel were reviewed and approved by the committee in 2025/26. During 2026/27, further work will continue to determine the most appropriate governance structures feeding into the committee, with the aim of strengthening the quality and flow of business from these panels, in particular. This will ensure that operational matters are addressed within the appropriate forums, enabling the committee to focus its time on strategic matters.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

20. There are no proposed amendments to the terms of reference for 2026/27 save for the adjustment to the prescribed attendees, with the removal of the Executive Director of Paramedicine from the membership.

PROPOSED CHANGES TO THE OPERATING ARRANGEMENTS

21. Proposed changes to operating arrangements for this committee are set out below. Some are relevant to arrangements across other committees also and they include:

    21.1. It was suggested that the committee may wish to explore inviting project leads for key areas of the charity's work, such as volunteering and staff well-being, or a representative from the Wish Ambulance (as the charity's new strategic projects begin).

COMMITTEE PRIORITIES

Priorities for 2025/26

22. The committee received an update on progress against its 2025/26 priorities at each meeting and as can be seen below, progress on agreed priorities has been good:

Priority	Progress
1. Governance of the Bids and Bursary Panels' operating arrangements, including their new terms of reference.	▪ The revised Terms of Reference for the **Bids Panel** were approved by the Charity Committee at the April 2025 meeting. ▪ The Chair of the Bids Panel, with the Head of Charity, has progressed a review of the expenditure guidance for the Bids Panel. The guidance was endorsed by the Bids Panel in December 2025, and it is before the Committee for approval at this meeting. ▪ The Chair of the Bids Panel intends to undertake a review of its operational effectiveness in quarter four of 2025/26 to inform the arrangements from quarter one of 2026/27. ▪ The Terms of Reference for the **Bursary Panel** were revised and approved by the Charity Committee in July 2025. ▪ Conversations are ongoing between the Chair of the Bursary Panel and the Head of Charity to review guidance documents and application processes. A verbal update will be provided by the Chair of the Bursary Panel at the meeting.

2. A development session for the Corporate Trustee, initially planned for last year, which has now been rescheduled with Withers Worldwide for February 2026 to explore the role of the Corporate Trustee.	▪ This session has been scheduled as part of the Board Development Day on 26 February 2026. The arrangements for this are being progressed by the Head of Charity. There will be no further update against this priority until the after the development session has been delivered.

Priorities for 2026/27

23. It is good practice for committees to set priorities for the forthcoming year when they review their effectiveness. The committee will do so at its April 2026 meeting, and these will be provided to the Corporate Trustee at its May 2026 meeting.

24. Progress on priorities will be reported to the committee quarterly and to the Corporate Trustee through its highlight report.

FINANCE AND PERFORMANCE COMMITTEE ANNUAL REPORT 2025/26

INTRODUCTION

1. The Trust's Standing Orders and committee terms of reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The committee met on 18 November 2025 and the 17 March 2026 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2025/26 and proposes changes to terms of reference.

5. The trust board has commissioned an external effectiveness review which will be undertaken in early 2026 by the Good Governance Institute (GGI). The GGI will be reviewing the board committee framework within quarter four 2025/26 and quarter one of 2026/27 which may necessitate further changes throughout 2026/27.

PURPOSE OF THE COMMITTEE

6. The committee is established to enable scrutiny and review of the Trust's arrangements in respect of the:

   - overall financial performance (both capital and revenue) of the Trust and its compliance with statutory financial duties.
   - ability of the Trust to deliver on its core objectives as set out in the Integrated Medium-Term Plan (IMTP).
   - monitoring performance against delivery of the IMTP and ensuring achievement of key milestones.
   - Review performance against targets and standards including those set by Commissioners and/or Welsh Government for the Trust.
   - robustness of any cost improvement measures and delivery of key strategies and plans.
   - ensure development of the long-term strategy and delivery of the Trust's strategic aims in relation to value and efficiency, including an increased focus on benchmarking.
   - scrutinise business cases for capital and other investment.
   - oversight of the development and implementation of the digital, estates, fleet, and environmental strategies.
   - business continuity including emergency preparedness, resilience and response, information governance and security, cyber security, and cyber resilience.

MEMBERSHIP AND ATTENDANCE

7. The committee met six times in private and in public as scheduled in 2025/26 and was quorate on each occasion.

8. The committee is supported by the Chair and two Non-Executive Directors as members, alongside several prescribed attendees who have demonstrated good levels of attendance. During the year, meetings of the Joint Commissioning Committee (JCC) clashed with this committee's meeting schedule. In addition, for part of the year the Executive Director of Strategy, Planning and Performance was undertaking the Interim Chief Executive Officer role, which resulted in her membership being deputised with full authority at several meetings. These scheduling JCC clashes will not occur in 2026/27.

9. The chart below illustrates attendance of members and prescribed attendees as listed in the terms of reference for 2025/26. The committee welcomed non prescribed attendees at various meetings as well as external guests.

COMMITTEE ATTENDANCE						
Name	**20 May 2025**	**21 Jul 2025**	**16 Sep 2025**	**18 Nov 2025[1]**	**20 Jan 2026**	**17 Mar 2026**
Jayne Beeslee (Chair)						
Bethan Evans					Colin Dennis	
Peter Curran			[2]			
Chris Turley			Ed Roberts	Ed Roberts		Ed Roberts
Rachel Marsh	Hugh Bennett	Hugh Bennett	Estelle Hitchon	Hugh Bennett	Hugh Bennett	From 10.30[3]
Lee Brooks				Judith Bryce		Sonia Thompson
Liam Williams	Wendy Herbert	Wendy Herbert				
Carl Kneeshaw						
Jonny Sammut			From 1022			Keith Dorrington
Trish Mills						
Hugh Parry				[4]		
Damon Turner						
Matt Dugdale						

(green)	Attended
(amber)	Deputy attended
(red)	Apologies received
(black)	No longer member

[1] Emma Wood, Chief Executive Officer joined for this meeting.
[2] Peter Curran left the meeting at 10.25. Rhiannon Beaumon-Wood joined at 10.30 and was counted towards quorum.
[3] James Houston deputising until 10.30
[4] Left for items 6 and 7

10. No changes to membership are proposed at this stage, noting however that may change following the outputs from GGI.

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

11. The committee undertook a light effectiveness review on 18 November 2025, as agreed with the Audit, Risk and Assurance Committee (ARAC). This was due to the comprehensive review undertaken in 2024/25 involving a detailed examination of the terms of reference and the assurance arrangements for each delegated responsibility.

12. For 2025/26 a survey of the members was carried out to gather feedback on the proposed changes to the terms of references and to identify what is working well, and where improvements could be made. The questions asked were:

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

13. The feedback from the committee included that members praised the committee's well-structured agendas, strong chairing, high-quality reporting, constructive scrutiny, transparent engagement from the Executive Leadership Team, and excellent corporate governance support. Suggested improvements centred largely on supporting members with complex or less-familiar areas of business, including potential bespoke development on fleet, estates and environmental matters; as well as continued work to improve the clarity and succinctness of reports.

14. Further recommendations included ensuring consistency in how key metrics are reported across committees, reducing duplication between committees, maintaining regular reviews of potential remit overlaps and conflicts of interest, and continuing to refine the quality and volume of committee papers through ongoing writing-guidance improvements.

15. The changes to the terms of reference were reviewed on the 18 November 2025 and were endorsed for review by the ARAC. The amendments agreed were the transferral of the oversight of assurance on value-based healthcare to the Quality, Patient Experience and Safety Committee, and the inclusion of assurance on the development of commercial partnerships, in addition to the Trust's commercial framework, from the Academic Partnership Committee.

Management of the committee's work programme

16. The committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee other than the waste management, noting however that the committee received assurances that there were no escalations in this regard. The annual capital revenue budget for 2026/27 had been scheduled on the cycle to be received in quarter four, however it was adjusted to be received in quarter one going forward which is more appropriate. The revised cycle of business was reviewed on the 17 March 2026.

17. The committee prepares its agenda aligned to the cycle of business in order to ensure it discharges its delegated responsibilities in a systemic way. Any deviation from the cycle is reported to the committee.

18. The board is kept informed of the committee's oversight of a range of issues by way of an 'Alert', 'Assure' and 'Advise' (AAA) report to the Board after each meeting. Any issues of concern are escalated to the board in the 'Alert' section, and the chair of this committee presents that report at each board meeting.

19. Other than that which is set out in this report, the substantial detail of the work of the committee in 2025/26 is included in the committee AAA reports which are linked below:

    19.1. AAA: 20 May 2025
    19.2. AAA: 21 July 2025
    19.3. AAA: 16 September 2025
    19.4. AAA: 18 November 2025
    19.5. AAA: 20 January 2026
    19.6. AAA: 17 March 2026

20. In year the committee has informed the ongoing review of the metrics within the Trust's Monthly Integrated Quality and Performance Report (MIQOR). This work has continued throughout quarter four and will continue into 2026/27 and included discussion at the February 2026 Board Development Day.

21. In private session the committee took matters that were commercially sensitive and confidential. Most matters made their way to the trust board private session and where appropriate were reported in public session in accordance with the standing orders. Other matters taken in private session included updates on the Manchester Arena Inquiry recommendations, as well as cyber key performance indicators and business cases.

22. The committee is not serviced by any sub-committees or task and finish groups that this time. In year, where papers were not published in line with the Trust's Board and Committee's Secretariat SOP, the late submission or publication was managed in discussion with the Chair on most occasions.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

23. There are only two material changes to the terms of reference for 2025/26, which are the transferral of the oversight of assurance on value-based healthcare to the Quality, Patient Experience and Safety Committee, and the inclusion of assurance on the development of commercial partnerships, in addition to the Trust's commercial framework, from the Academic Partnership Committee.

24. Proposed changes to the operating arrangements for this committee set out below, were agreed on the 18 November 2025:

    24.1. Members are encouraged to provide feedback on reports after meetings, should that be considered appropriate. This was on reflection of the volume and length of papers.
    24.2. Report authors are encouraged to seek advice from the Corporate Governance Team should further support be required when preparing papers.

COMMITTEE PRIORITIES

Priorities for 2025/26

25. The committee received an update on progress against its priorities at each meeting. The 2025/26 priorities were:

Priority	Progress
A focus on financial sustainability	• It was agreed that an update on the Financial Sustainability Programme will be received at every other meeting of the Committee, and as such was programmed for July 2025, November 2025 and March 2026 (on the Committee Cycle of Business). The November 2025 and March 2026 updates were received as scheduled, and additional progress reported, including the evolution of the commercial plan, which was received in March 2026.
A focus on Clinical Model Transformation performance	• The August 2025 meeting focused on the implementation of Phase 2 of the Ambulance Performance Framework. The committee provided assurance to the board on readiness ahead of the extraordinary Quality, Patient Experience and Safety Committee and board meetings in October 2025. • Updates on the progress of CMT delivery are included as part of the Integrated Medium-Term Plan (IMTP) Progress Report which is received at every meeting of the committee. • An update on Phase 2 go-live was received at the November 2025 meeting. The committee were assured that plans were in place for Phase 2 go-live in early December 2025. An assurance piece regarding clinical response in rural areas was due to in March 2026 but deferred to May 2026.

Priority	Progress
	• The internal audit report on the governance arrangements for the Clinical Model Transformation programme management was received at the March 2026 meeting
A focus on resilience including information security	• The Information Governance (IG) Report received at every meeting highlights ongoing efforts to enhance information governance and data protection within the Trust, addressing both compliance requirements and operational challenges. • As part of the additional funding secured for the Digital Directorate in 2024/25 and 2025/26, a significant recruitment programme is ongoing to strengthen capacity within the directorate.
A focus on the progress of the Manchester Arena Inquiry recommendations	• The committee received progress updates against the Manchester Arena Inquiry (MAI) with regards to the recommendations required via the Operations Directorate report received at each meeting. • An update on the progress of recommendations and the case submitted to Welsh Government was received in the private session of the September 2025 and November 2025 meetings. A further separate update was also received at the private meeting in January 2026.

PEOPLE AND CULTURE COMMITTEE ANNUAL REPORT 2025/26

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that boards should routinely assess the effectiveness of their governance arrangements, of which the Trust Board's Committees form an integral part.

4. The People and Culture Committee met on 13 November 2025 and 10 February 2026, and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2025/26 and proposes changes to terms of reference.

5. The Trust Board has commissioned an external effectiveness review which will be undertaken in early 2026 by the Good Governance Institute (GGI). The GGI will be reviewing the board committee framework within quarter four 2025/26 and quarter one of 2026/27 which may necessitate further changes throughout 2026/27. Although at this stage it is not anticipated that there will be material changes to this committee.

PURPOSE OF THE COMMITTEE

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

MEMBERSHIP AND ATTENDANCE

7. The committee met four times as scheduled in 2025/26 and was quorate on each occasion.

8. The committee is supported by the Chair and three Non-Executive Directors (NED) as members, and several core attendees with good attendance. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2025/26. The committee welcomed non prescribed attendees at various meetings as well as external guests.

COMMITTEE ATTENDANCE				
Name	15 May 2025	12 August 2025	13 November 2025	10 February 2026
Ceri Jackson				
Bethan Evans				
Hayley Hutchings				
Hannah Rowan				
Angela Lewis				
Carl Kneeshaw				
Chris Turley				
Lee Brooks	From item 6	Sonia Thompson	From item 5	
Penny Durrant				
Estelle Hitchon				
Andy Swinburn		Greg Lloyd		
Alex Crawford		James Houston	Hugh Bennett	
Trish Mills				
Lizzie O'Shea				
Damon Turner				
Marcus Viggers			Left for items 9-13	
Christian Fox			Hugh Parry	
Tim Cahalane				

9. As can be seen above attendance is excellent. No changes to membership are proposed at this stage, noting however that may change following the outputs from GGI.

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

10. The committee undertook a light effectiveness review on 13 November 2025, as agreed with the Audit, Risk and Assurance Committee (ARAC). This was due to the comprehensive review undertaken in 2024/25 involving a detailed examination of the terms of reference and the assurance arrangements for each delegated responsibility.

11. For 2025/26 a survey of the members was carried out to gather feedback on the proposed changes to the terms of references and to identify what is working well, and where improvements could be made. The questions asked were:

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

12. The feedback from the committee included that the committee is valued for its inclusivity, active participation, and high-quality reporting, which foster a collaborative environment and effective assurance to the board. There is a desire for the committee to focus more on strategic priorities and to measure the tangible impact of its work, ensuring that discussions address the most pressing and relevant issues for staff and the organisation.

13. The changes to the terms of reference were reviewed on the 13 November 2025 and were endorsed for review by the ARAC. The amendments agreed were to include broader education and training matters, related partnership and collaboration, and the corresponding membership changes to reflect these updates.

14. Following discussion on the 13 November it was agreed to add in provision 13.4, '*Provide oversight of the Trust's approach to education, training, and development for all staff, ensuring programmes are comprehensive, accessible, and aligned with organisational priorities and values'*. Related to this, the Head of Workforce and Education will be a prescribed attendee.

15. The reporting against the remit of the committee now including collaboration with education partners this provision will be developed throughout 2026/27, through discussion with the Director of People and Director of Culture Change.

Management of the committee's work programme

16. The committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the committee and in this respect, it has discharged its responsibilities in providing assurance to the board. The area of reporting on 'learning and development' will continue to be developed into 2026/27. The revised cycle of business for the committee was reviewed at the meeting on the 10 February 2026.

17. The committee prepares its agenda aligned to the cycle of business in order to ensure it discharges its delegated responsibilities in a systemic way. Any deviation from the cycle is reported to the committee.

18. The board is kept informed of the committee's oversight of a range of issues by way of an 'Alert', 'Assure' and 'Advise' (AAA) report to the Board after each meeting. Any issues of concern are escalated to the board in the 'Alert' section, and the chair of this committee presents that report at each board meeting.

19. Other than that which is set out in this report, the substantial detail of the work of the committee in 2025/26 is included in the committee AAA reports which are linked below:

    19.1. AAA: 15 May 2025
    19.2. AAA: 12 August 2025
    19.3. AAA: 13 November 2025
    19.4. AAA: 10 February 2026

20. The committee is serviced by one sub-committee, the Welsh Ambulance Services Partnership Team (WASPT). This is the Trust's Local Partnership Forum. The Committee received a AAA report from WASPT at each meeting.

21. The private business received in year included receipt of the suspensions over four months.

22. In year all papers were published in line with the Trust's Board and Committees Secretariat Standard Operating Procedure except for the May 2025 publication of the Monthly Integrated Quality and Performance Report.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

23. There are only two material changes to the terms of reference for 25/26, and that is the inclusion of broader education and training, related partnership and collaboration, and the corresponding membership changes to reflect these updates. This was endorsed by the committee on the 13 November 2025 and approved by the board on the 29 January 2026.

24. Proposed changed to operating arrangements for this committee set out below were agreed on the 13 November 2025:

    24.1. To hold discussions in 2026/27 on the committee specific metrics following the revision of the MIQPR and consider the onward committee reporting.

    24.2. Continue to encourage stakeholders to observe the open committee meeting.

    24.3. 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.

COMMITTEE PRIORITIES

Priorities for 2025/26

25. The Committee received an update on progress against its priorities at each meeting. The 2025/26 priorities were:

Priority	Progress
• A focus on Equality, Diversity and Inclusion	• At the November 2025 meeting, the committee received the Workforce Race Equality Standards (WRES) Annual Report 2024/25. • At the August 2025 meeting, the committee received the following suite of Strategic Equality Reports 2024/2025: - Strategic Equality Plan Annual Report 2024/25 - Annual Gender Pay Gap Annual Report 2024/25 - Annual Workforce Quality Monitoring Report Annual Report 2024/25 • The Welsh Language Report was presented at the August 2025 meeting. Within this update the Committee also received receive the year 3 "More Than Just Words" Action progress report for assurance.
• The Trust's approach to development of our people.	• At the February 2026 meeting the committee received the Education Commissioning Report which incorporates pre-registration commissioning for commencement for studies in financial year 2027/28 and all other commissioning for commencement of studies in financial year 2025/26. • At the February 2026, the committee also received the Skills Mix on Emergency Ambulances paper. The ongoing Skills Mix work related to the Clinical Model Transformation and Ambulance Performance Framework has been taken into consideration regarding the impact on Education Commissioning requirements alongside the financial settlement and budget pressures. • At the November 2025 meeting it was agreed to amend the TOR to include development and training for a broader staff group and membership to reflect that update. It discussed senior EMD training, apprenticeships, EAP training, and the training provided for staff ahead of the go-live of Phase two of

	the CMT. The lived experience was from the essential skills tutors. • At the November 2025 meeting the committee received the People and Culture Plan extension, and the purpose of which as to discuss and support the proposal to extend the current People and Culture Plan (2023-26), until at least April 2027. This was based on its continued relevance, alignment with strategic priorities, and timeframes to refresh the Trust Long-Term Strategic Framework. • At the November 2025 committee meeting the presentation from the Essential Skills Tutors highlighted the breadth and diversity of experience within their team. This illustrated how their collective strengths foster an inclusive environment, where individual contributions are valued and complement each other. The Committee gained an understanding of how Essential Skills initiatives help advance shared objectives and promote ongoing development for all members of WAST. • A progress update on the People Development Plan was received at August 2025 meeting. The committee were updated on the progress made in implementing the People Development Plan and the development of the supporting policy. The Committee received an overview of the ongoing work to develop professional group frameworks and associated professional proficiencies. The Committee were informed of the outline of the next phase of planned activity and priorities. • At the May 2025 meeting, the committee received the People and Culture Plan Metrics, which highlighted: - an increase in PADR completion rates reflected for March (82.38%); This represents the highest recorded rate within this dataset. PADR process improvements are in progress with a focus on

	making the conversation the core of the process, with the form acting as a simple tool to guide (not define) the discussion. - an increase in statutory and mandatory training compliance (87.84%, against a Welsh Government target of 85%). At 31st March 2025, 90.44% of colleagues required to attend Mandatory In-Service Training (MIST) had done so. *2024/25 Progress (included as this priority was carried over into 2025/26)* - At its meeting in May 2024 the committee received the 'Staff Development Outline Plan' which was a deliverable of the People & Culture Plan. The aim of this was to provide equity in development opportunities for our people to undertake their roles and benefit from progression opportunities. - At the May 2024 meeting the committee were assured that mapping was underway on professions and roles, which define skills and competencies. It was noted that the 'Learning and Development' reporting was still in development. - The People and Culture Plan metrics – which the committee receives at every meeting – includes metrics regarding the statutory and mandatory training (giving organisational compliance figures) in addition to the MIST compliance. - The People and Culture Plan metrics provided to the committee also included qualitative feedback regarding the Trust's learning and development initiatives, which enables us to take a continuous improvement approach to the development of our people.

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE (QUEST) ANNUAL REPORT 2025/26

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, committee terms of reference, and codes of governance provide that boards should routinely assess the effectiveness of their governance arrangements, of which the board's committees form an integral part.

4. The committee met on the 4 November 2025 and 3 February 2026, and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2025/26 and proposes changes to terms of reference.

5. The trust board has commissioned an external effectiveness review which will be undertaken in early 2026 by the Good Governance Institute (GGI). The GGI will be reviewing the board committee framework within quarter four 2025/26 and quarter one of 2026/27 which may necessitate further changes throughout 2026/27. Although at this stage it is not anticipated that there will be material changes to this committee.

PURPOSE OF THE COMMITTEE

6. The committee is established to scrutinise improvements in outcomes in quality, patient experience, effectiveness, and safety to reduce incidences of avoidable harm. It provides oversight of and seeks assurance on statutory and regulatory compliance, including but not limited to the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

MEMBERSHIP AND ATTENDANCE

7. The committee met six times in 2025/26 and was quorate on each occasion. Of the six meetings this year two were extraordinary (13 June and 10 October) and were convened to transact urgent matters of business related to the Clinical Model Transformation Programme.

8. The committee is supported by the Chair and two Non-Executive Directors as members, and a number of prescribed attendees. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2025/26. The committee welcomed non prescribed attendees at various meetings as well as external guests.

COMMITTEE ATTENDANCE						
NAME	9 MAY 2025	13 JUN 2025[1]	5 AUG 2025	10 OCT 2025[2]	4 NOV 2025	3 FEB 2026
Bethan Evans (Chair)						
Ceri Jackson						
Rhiannon Beaumont-Wood						
Liam Williams						
Andy Swinburn			Jonathan Chippendale			
Lee Brooks	Peter Brown				Mark Harris	
Rachel Marsh			Hugh Bennett		Hugh Bennett	
Jonny Sammut	Keith Williams					
Trish Mills		Julie Boalch		Julie Boalch		
Mark Marsden						
Hugh Parry					From item 6.1	
Henry Garrard						

(green)	Attended
(amber)	Deputy attended
(red)	Apologies received
(black)	No longer member

[1] Extraordinary meeting
[2] Extraordinary meeting

9. As can be seen above attendance is excellent. No changes to membership are proposed at this stage, noting however that may change following the outputs from GGI.

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

10. The committee undertook a light effectiveness review on 4 November 2025, as agreed with the Audit, Risk and Assurance Committee (ARAC). This was due to the comprehensive review undertaken in 2024/25 involving a detailed examination of the terms of reference and the assurance arrangements for each delegated responsibility.

11. For 2025/26 a survey of the members was carried out to gather feedback on the proposed changes to the terms of references and to identify what is working well, and where improvements could be made. The questions asked were:

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

12. The feedback from the committee included that there was broad agreement that the committee's membership is appropriate and diverse, and whilst concerns were raised about the number of attendees, with some questioning the value added by non-contributing participants, wide attendance is encouraged and welcomed by the committee in open session.

13. The committee is seen as effective with high engagement, robust agendas, and strong scrutiny and chairing. However, there is a desire for more focus on the effectiveness of the Quality Management System as a whole, including quality planning, control, and improvement; not just assurance.

14. The terms of reference are viewed as suitable and were endorsed by the committee on 4 November, subject to changes which transfer responsibility for value based healthcare from the Finance and Performance Committee. These matters are reflected in the cycle of business for the committee for 2026/27.

Management of the committee's work programme

15. The committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the committee and in this respect, it has discharged its responsibilities in providing assurance to the Board. The revised cycle of business for the committee was reviewed at the meeting on the 3 February 2026.

16. The committee prepares its agenda aligned to the cycle of business in order to ensure it discharges its delegated responsibilities in a systemic way. Any deviation from the cycle is reported to the committee.

17. The board is kept informed of the committee's oversight of a range of issues by way of an 'Alert', 'Assure' and 'Advise' (AAA) report to the Board after each meeting. Any issues of concern are escalated to the board in the 'Alert' section, and the chair of this committee presents that report at each board meeting.

18. Rather than set out in this report the substantial detail of the work of the committee in 2025/26, the AAA reports for all six meetings are linked below.

    18.1. AAA: 9 May 2025
    18.2. AAA: 13 June 2025 (extraordinary meeting)
    18.3. AAA: 5 August 2025
    18.4. AAA: 10 October 2025 (extraordinary meeting)
    18.5. AAA: 4 November 2025
    18.6. AAA: 3 February 2026

19. The committee is not currently serviced by any sub-committees.

20. The private business received in year included receipt of closed risk management discussions.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

21. There is only one material change to the terms of reference and that is the inclusion of the 'receipt of assurance on the delivery of core aims in relation to delivering value and development of value based healthcare in an out of hospital setting', transferred from the Finance and Performance Committee. This was endorsed by the committee on 4 November and will be approved by the board on 29 January.

22. Proposed changes to operating arrangements for this committee set out below were agreed on 4 November:

    22.1. Committee to consider how to focus business in relation to quality management systems, given the existing provision of the terms of reference (3.6). It was agreed to be for the Executive Director of Quality and Nursing to take account of this for future committee reporting.

    22.2. 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.

    22.3. To encourage the use of dashboard reporting where possible, and for the use of presentations to be proportionate. The recently published report and presentation guidance will support this approach.

    22.4. To encourage a focus on outcomes and achievement of deliverables, where organisational plans are agreed.

    22.5. To hold discussions in 2026/27 on the committee specific metrics following the revision of the MIQPR and consider the onward committee reporting.

COMMITTEE PRIORITIES

Priorities for 2025/26

23. The committee received an update on progress against its priorities at each meeting. The 2025/6 priorities were:

Priority	Progress
• Continued monitoring and reporting on performance against the Duty of Quality and Duty of Candour	• The committee receives the PTR report at each meeting with focused discussion on the metrics that demonstrate how the Trust meets it statutory duties. At the August and November 2025, and February 2026 meetings, the Putting Things Right (PTR) recovery plan was reviewed. • At the February 2026 meeting the quarter three Putting Things Right (PTR) report was received at this meeting. The committee noted that despite significant additional resources, improvement has not been achieved, and performance has deteriorated for some indicators. Further context to this report is in the associated AAA. • The Duty of Quality Annual Report 2024/25 was received by the committee at its meeting on 13 June 2025 and was approved by the Trust Board on 26 June 2025 for publication. • Future updates on the implementation of the Duty of Candour and Duty of Quality will be programmed as required, informed by the prompts on the Cyle of Business.
• Prioritising the implementation of the new Strategic Quality Plan to ensure tangible outcomes	• The committee received the Strategic Quality Plan 2025-28 Quarterly Update at the meeting on 3 February 2026. Members will be asked to note the key risks, dependencies and capacity constraints impacting delivery, and the mitigating actions in place. The committee endorsed continued quarterly assurance reporting and welcomed a move toward outcome-based measures as the plan matures.

	• The committee received a progress update against the delivery of the Strategic Quality Plan 2025/28 at the November 2025 meeting. This followed the receipt of the Strategic Quality Plan 2025-2028 by the Committee at its meeting on 09 May 2025, which was approved by the Trust Board approved the plan on 29 May 2025.
• Focus on the Clinical Model Transformation, ensuring robust quality assurance and patient experience improvements	• The committee held an extraordinary meeting in October 2025 to review and endorse the Quality Impact Assessment and Equality Impact Assessment for the phase two go-live of the revised Ambulance Performance Framework (APF), ahead of the extraordinary Trust Board meeting to approve the go-live of phase two APF • The committee continues to monitor progress through regular updates and highlight reports; scrutiny of evaluation findings and interim reports; and assurance that the transformation aligns with statutory duties and strategic goals. • Verbal updates on the Ministerial Advisory Group Wait-45 Taskforce and Revised Performance Framework were provided at the August 2025 and February 2026 meetings. This activity is not a part of the Clinical Model Transformation; however, it is often discussed in relation to this organisational change.

REMUNERATION COMMITTEE ANNUAL REPORT 2025/26

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The committee met on 4 December 2025 and 13 March 2026 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2025/26 and proposes changes to terms of reference.

5. The trust board has commissioned an external effectiveness review which will be undertaken in early 2026 by the Good Governance Institute (GGI). The GGI will be reviewing the board committee framework within quarter four 2025/26 and quarter one of 2026/27 which may necessitate further changes throughout 2026/27. Although at this stage it is unlikely that there will be material changes to this committee.

PURPOSE OF THE COMMITTEE

6. The purpose of the committee is to:
   (a) Approve on behalf of the Board matters relating to the appointment, termination, remuneration, terms of service and appraisal for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government and in accordance with the Standing Orders; and
   (b) Approve proposals regarding termination arrangements, including those under the Voluntary Early Release Scheme, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.
   (c) Provide assurance to the Board in relation to the Trust's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales.

MEMBERSHIP AND ATTENDANCE

7. The committee has meetings scheduled four times a year, however given the nature of the work of this committee, they can sometimes be moved because there are limited issues to review. At other times additional meetings are required depending on demand.

8. During 2025/26 the committee met seven times; three of which were extraordinary and closely linked to the appointment of the new Chief Executive. Meetings were quorate on each occasion. The committee has been supported by the Chair and all of the non-executive directors as members, as with several prescribed attendees.

9. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2025/26.

COMMITTEE ATTENDANCE							
Name	15 May 2025[1]	3 June 2025[2]	11 July 2025[3]	25 July 2025[4]	3 Sept 2025	4 Dec 2025	13 Mar 2026
Colin Dennis							
Rhiannon Beaumont Wood							
Peter Curran							
Bethan Evans							
Prof. Hayley Hutchings							
Ceri Jackson							
Hannah Rowan							
Jayne Beeslee							
Jason Killens							
Rachel Marsh							
Emma Wood							
Carl Kneeshaw							
Trish Mills				Recused for JD item			
Hugh Parry							
Damon Turner							

	Attended
	Sent Deputy
	Apologies
	No longer a member.

[1] Extraordinary meeting
[2] Jason Killens was recused for the discussion on the CEO's outturn position for 2024/25
[3] Extraordinary meeting
[4] Extraordinary meeting

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

10. The committee undertook a light effectiveness review on 4 December 2025 as agreed with the Audit, Risk and Assurance Committee (ARAC). This was due to the comprehensive review undertaken in 2024/25 involving a detailed examination of the terms of reference for all board committees, and the assurance arrangements for each delegated responsibility.

11. For 2025/26 a survey of the members was carried out to gather feedback on the proposed changes to the terms of references and to identify what is working well, and where improvements could be made. The questions asked were:

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

12. The feedback from the committee included that the Remuneration Committee is functioning effectively, with clear, focused agendas; succinct and well-presented papers; strong attendance and engagement; and constructive, open discussion supported by good governance and executive input. Members confirmed no changes were needed to the terms of reference or membership for 2026/27, though some queried the rationale for full NED membership and the quorum of three, both of which reflect established NHS best practice and wider Board expectations.

13. While the committee's agility and clarity of purpose were praised, two areas for improvement were noted: exploring whether quarterly meetings could be aligned with other scheduled sessions, while recognising the practical constraints of already-busy dates and varied committee memberships; and ensuring topics never feel pre-determined, with members reminded that papers are issued seven days in advance to enable clarification and challenge ahead of meetings.

14. There were no material changes to the committee terms of reference proposed and no specific changes to the operating arrangements are proposed following the above positive comments, other than those that are relevant for all committees.

Management of the committee's work programme

15. The committee has a cycle of business that is aligned to its terms of reference, albeit there are limited opportunities to proactively plan the work of this committee. All matters scheduled for oversight and review have been brought to the committee.

16. The board is kept informed of the committee's oversight of a range of issues by way of an 'Alert', 'Assure' and 'Advise' (AAA) report to the Board after each meeting. Any issues of concern are escalated to the board in the 'Alert' section, and the chair of this committee presents that report at each board meeting.

17. Other than that which is set out in this report, the substantial detail of the work of the committee in 2025/26 was included in the committee AAA reports into both private and public board meetings where appropriate. All of the business scheduled for receipt in line with the committee's cycle of business was received as planned.

18. The committee is a private committee of the board. In year there were several papers were published later than the required deadline, in line with the Trust's Board and Committees Secretariat Standard Operating Procedure (SOP). All these were managed and published ahead of each meeting in agreement with the committee Chair.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

19. The proposed changes to terms of reference for this committee for 2025/26 were minimal and only included an additional sentence in provision 8.1 (a) "while retaining discretion to limit or delay reporting if the matters discussed are particularly sensitive' in relation to the reporting of the committee's activities to the board.

20. It was not considered necessary to adjust the membership of the committee despite varied practices across NHS Wales. However, given the matters considered by the committee are often highly sensitive it was agreed that inviting the full Non-Executive Director membership provides the appropriate level of oversight and assurance.

21. The Executive Director of Finance and Corporate Resources must have signed off the relevant budget for any settlement agreements presented to the committee for approval; however, the Executive Director of Finance and Corporate Resources may be asked to attend where VERS or other settlement applications are being considered.

22. Given the somewhat reactive nature of the committee, it does not set annual priorities.

AUDIT, RISK AND ASSURANCE COMMITTEE ANNUAL REPORT 2025/26

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The committee met on 2 March 2026 to review the outcome of the committee sub-group review of the National Audit Office toolkit, its terms of reference, and its operating arrangements. This annual report reflects on the effectiveness of the committee in 2025/26 and proposes changes to terms of reference.

5. The trust board has commissioned an external effectiveness review which will be undertaken in early 2026 by the Good Governance Institute (GGI). The GGI will be reviewing the board committee framework within quarter four 2025/26 and quarter one of 2026/27 which may necessitate further changes throughout 2026/27, including potential material changes to this committee.

PURPOSE OF THE COMMITTEE

6. The purpose of the committee is to advise and assure the board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales. Where appropriate, the committee will advise the board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

MEMBERSHIP AND ATTENDANCE

7. The committee met five times in public and four times in private session as scheduled in 2025/26 and was quorate on each occasion. Pre-meets were held with the Chair and Auditors.

8. In 2025/26 the Committee was supported by the Chair and three Non-Executive Directors (NEDs) as members, and several prescribed attendees with good attendance

9. As at year end of the committee membership is Peter Curran, Ceri Jackson and Rhiannon Beaumont-Wood. Rhiannon Beaumont-Wood left the trust board on the 8 February 2026 and consequently the committee membership from the same date.

10. The chart below illustrates attendance of members and prescribed attendees as listed in the terms of reference for 2025/26. Audit Wales and Internal Audit were in attendance, and the committee welcomed non prescribed attendees at various meetings. The Chief Executive Officer attended two meetings in 2025/26: Jason Killens attended the June 2025 meeting, and Emma Wood (Chief Executive effective 1 October 2025) attended the December 2025 meeting. The committee welcomed non prescribed attendees at various meetings as well as external guests.

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

Colour	Key
Green	Attended
Amber	Deputy attended
Red	Apologies received
Black	No longer member

[1] The chairs of the Finance and Performance Committee (Jayne Beeslee) and QUEST (Bethan Evans) were in attendance for the committee effectiveness reviews
[2] Jason Killens, CEO, joined for the presentation and endorsement of the annual report and audited accounts
[3] Emma Wood, CEO joined this meeting

COMMITTEE VIEWS ON EFFECTIVENESS

Feedback from membership

11. In previous years, members of the committee were asked to complete the extensive NAO Audit and Risk Assurance Committee Effectiveness Toolkit questionnaire. Recognising the need for a more engaging and efficient process, the committee adopted a new approach for the current effectiveness review, commencing in April 2024 This process was also applied to the 2025 review.

12. A subgroup of ARAC members met to address the 180 questions in the toolkit by identifying and addressing any gaps in advance. This preliminary work aims to streamline the effectiveness review by allowing the committee to focus on key areas of improvement and maintain continuous oversight of their responsibilities.

13. The ARAC sub-group agreed that the 2025/26 responses to the questions were appropriate and spent time reviewing the three areas below in more detail:

    A. Communication: Question 1.2.9 indicates that it is good practice for the ARAC Chair and others to keep in touch on a continuing basis between meetings:

- Members agreed that they remain connected through touchpoint meetings during the year, and Non-Executive Director (NED) meetings allow the ARAC Chair to raise any issues with NED colleagues. Regular meetings of the ARAC sub-group take place with the recent focus being the review of the board's committee framework. There were no changes requested to these arrangements.

- The ARAC Chair and the Executive Director of Finance and Corporate Resources also meet regularly on a one-to-one basis, and both attend agenda setting meetings. The Chair also meets with the auditors regularly, and it was agreed that the sub-group will continue to meet quarterly with the Chair feeding back to the committee on issues discussed.

B. Skills and experience of members:

- Sub-group members noted that committee members are appointed for their experience and skills, particularly executive and senior leaders whose portfolios align with a committee's remit. Where a committee does not have specific expertise in an area, members are encouraged to seek bespoke development, either through the board development programme or through deep dive sessions. This is particularly important in areas identified in the toolkit such as cyber, digital, environmental and sustainability, commercial and procurement.

- The sub-group proposed that this issue is raised at board to ensure that, pending the broader review of the skills mix, chairs of all board committees (including ARAC) continue to encourage targeted upskilling where it is needed. This will help maintain robust oversight and understanding, while avoiding the risk of committees becoming overly operational. The ARAC agreed that this should be taken forward, with the ARAC overseeing progress/development.

- Related to this, the sub-group recognised that there may be work for ARAC to undertake at board level to review the board skills matrix, to ensure it is fit for purpose and that the distribution of NEDs and directors across committees aligns with remit and the matrix. The ARAC agreed with the proposal from the sub-group that this should be taken forward, with the ARAC overseeing progress/development. It was agreed that the ARAC subgroup would progress development of a refined skills matrix, aligned to organisational priorities and committee responsibilities. This work will be brought back to ARAC before being reported to the Board.

Management of the committee's work programme

14. The committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee and in this respect, it has discharged its responsibilities in providing assurance to the board aligned to its terms of reference. The revised cycle of business for the committee was reviewed at the meeting on the 28 April 2026.

15. The board is kept informed of the committee's oversight of a range of issues by way of an 'Alert', 'Assure' and 'Advise' (AAA) report to the Board after each meeting. Any issues of concern are escalated to the board in the 'Alert' section, and the chair of this committee presents that report at each board meeting.

16. Other than that which is set out in this report, the substantial detail of the work of the committee in 2025/26 is included in the committee AAA reports which are linked below:

    16.1. AAA: 1 May 2025
    16.2. AAA: 24 June 2025
    16.3. AAA: 25 September 2025
    16.4. AAA: 2 December 2025
    16.5. AAA: 2 March 2026

17. The board received a highlight (AAA) report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. This AAA report included reporting at a high level of matters taken in private session.

18. The committee is not serviced by any sub-committees or task and finish groups that this time in addition to the sub-group which considered the NAO effectiveness tool. In year, all papers were published in line with the trust's board and committee's secretariat standard operating procedure,

PROPOSED CHANGES TO THE TERMS OF REFERENCE

19. The proposed changes to terms of reference for this committee for 2025/26 were endorsed by the committee at its meeting on the 2 March 2026. The only change proposed is the adjustment to the membership to include the Deputy Director of Quality and Putting Things Right in place of the Executive Director of Quality and Nursing.

COMMITTEE PRIORITIES

Priorities for 2025/26

20. The committee received an update on progress against its priorities at each meeting. The 2025/26 priorities were:

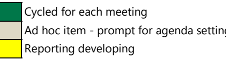
Priority	Progress
• Monitoring progress of the committee effectiveness review 'part II' throughout 2025/26 (as set out at the 01 May 2025 ARAC) with respect to the committee delegations, membership and meeting frequency.	• This committee reviewed its own quality and governance at the March 2026 meeting and completed the discussion with the review of the annual report from 2025/26 and cycle of business for 2026/27 at the April 2026 meeting. • In December 2025 the committee considered the options for the wider board committee framework changes and endorsed option 1, to be deferred until the outcomes of the externally facilitated board effectiveness review are received and considered (noting this may be mid-year in 2026/27). They also approved the approach to the quality and effectiveness review for ARAC, being that the ARAC sub-group will review the NAO effectiveness toolkit and provide this and any key issues to the March 2026 meeting, alongside responses to a short qualitative survey of members. They also recommended to the board that their quality and governance review includes a repeat of the survey conducted in 2024/25. • A project plan was agreed with a sub-group of ARAC. The Director of Corporate Governance/Board Secretary presented a paper at the meeting of the Audit Risk and Assurance Committee on 2 September 2025 regarding the 2025/26 Effectiveness Review and has facilitated an ongoing discussion with a sub-group of ARAC regarding this work.

PAPER	PRE or POST C'EE FORUM	FREQUENCY	Q1a	Q1b	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
AUDIT, RISK AND ASSURANCE COMMITTEE - CYCLE OF BUSINESS 2026/27										
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	Review of self-assessment by AC ahead of declaration of same in annual report in Q1b
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
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	Amendments to standing orders, standing financial instructions, scheme of reservation and delegation and associated schedules
Breach of Standing Orders & Standing Fin. Instructions	ELT	Ad Hoc						BS	Discussion/Assurance	
Non-compliance with SO: publication of late papers	ELT	Quarterly						BS	Discussion/Assurance	Agreed to be received six monthly (and first report received in March 2026)
Governance Practice Notes	ELT	Annually						BS	Approval	Annual review of practice notes related to SOs and SFIs
Whistleblower, Declarations, Gifts & Hospitality										
Annual report on declarations of interest	ELT	Annually						BS	Assurance	Audit committee to provide report to Board on adequacy of arrangements for DOI annually
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	This includes the annual report and amendments to TORs for all Board Committees and WASPT
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	
Review of Governance Practice Notes	n/a	Biennially						BS	Approval	
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



Cycled for each meeting

Ad hoc item - prompt for agenda setting

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.

Internal Audit Progress Report

Audit, Risk and Assurance Committee

April 2026

Welsh Ambulance Services University NHS Trust

NWSSP Audit and Assurance Services

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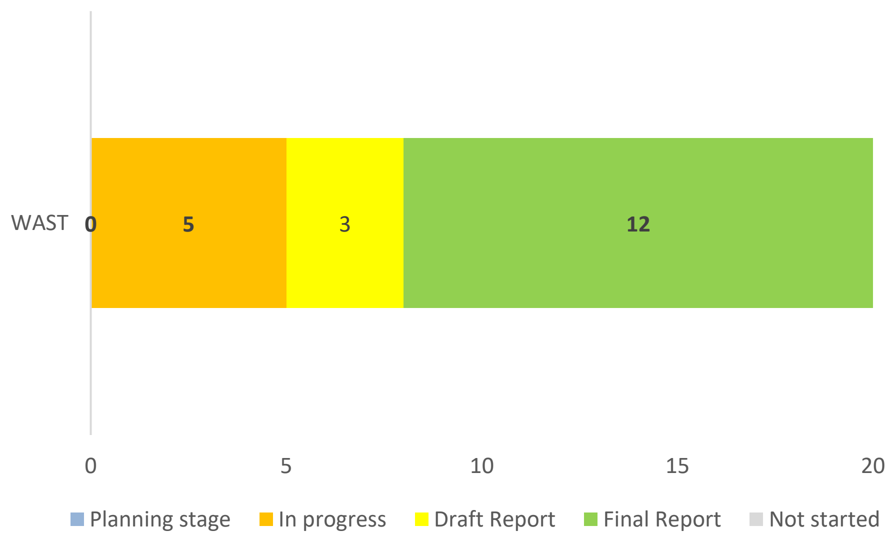
1. Introduction

The purpose of this report is to:

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

2. Progress against the 2025/26 Internal Audit Plan

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



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

3. Proposed changes to the approved plan

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

4. Follow Up of Internal Audit Recommendations

As previously communicated and agreed with the Trust, we have introduced a revised approach to follow up for the 2025/26 Internal Audit plan year. A minimum of 50% of high priority findings and 10% of medium priority findings from internal audit reports issued during 2024/25 will be subject to review throughout the year. Selection will be based on those recorded as closed within the Trust's recommendation tracker.

A rolling sample of closed recommendations has been validated during the year, with updates provided at each meeting of the Audit, Risk and Assurance Committee (ARAC) meeting. To date, conclusions from three follow-up reviews have been reported:

- Recommendations with an expected implementation date on or before 31 March 2025, were reported to the December 2025 ARAC.
- Recommendations with an expected implementation date on or before 31 May 2025 and 30 September 2025, aligning with the Quarter 1 and Quarter 2 updates provided by the Head of Compliance & Assurance, were both reported to the March 2026 ARAC.

Our fourth review focussed on recommendations due for implementation on or before 31 December 2025, which aligns with the Quarter 3 update provided by the Head of Compliance & Assurance.

Progress Against Recommendations

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

- 38 recommendations were expected to be closed by 31 March 2025, of which 26 (68.4%) were closed.
- 15 recommendations, including the remaining seven from 31 March 2025, were expected to be closed by 31 May 2025. Closure was recorded for four (26.6%) of these. Of the 11 remaining open items, all had revised target dates recorded on the tracker: 6 in Quarter 2 of 2025/26 and five in Quarter 3.
- 30 recommendations, including nine from our previous two reviews, were expected to be closed by 30 September 2025. Closure had been recorded for 22 (73.3%) of these. Of the eight remaining open items, seven had revised target dates recorded: two in Quarter 3 of 2025/26 and five by the end of the financial year. One item was still pending assignment of a target date.
- A further 27 recommendations, including seven from earlier reviews with revised target dates, were expected to be closed by 31 December 2025. Closure was recorded on the tracker for eight (30%) of these. Of the 19 remaining open items, all had revised target dates recorded: five by the end of the financial year, five in Quarter 1 of 2026/27 and seven in Quarter 2. Two items were still pending assignment of a target date.

Overall, 60 of the 87 recommendations expected to be closed by 31 December 2025 have been recorded as closed, representing a closure rate of 69%. We recognise that 17 of these recommendations had revised implementation dates assigned.

Validation Activity

A sample of two recommendations (one high priority and one medium priority) from two reports was selected for validation (see **Table 1 in appendix B**), and a further four recommendations were carried over from previous reviews (see **Tables 2 & 3 in appendix B**).

Sufficient evidence was provided to confirm closure for four of the recommendations. At the date of reporting, we have been unable to conclude on two recommendations (from the Seasonal Modelling and Forecasting and Emergency Nurse Communications System Implementation reports), as additional evidence has been requested.

Across all reviews completed to date, closure has therefore been agreed with 13 out of the 16 recommendations sampled.

Next Steps

The next follow-up review will consider recommendations with an expected implementation date of 31 March 2026, aligning with the financial year-end. A further 13 recommendations (including five from earlier reviews with revised target dates) from 2024/25 audits are expected to fall within this period and will form the population for the next sample. Our conclusions will be reported to the June ARAC, through a year-end summary report capturing the overall position for the year.

5. Engagement

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

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

6. Key Performance Indicators

Correct on 31 March 2026

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2025/26	●	March	By 30 June
Audits reported over planned	●	15	15
Work in progress		5	
Report turnaround: time from fieldwork completion to draft reporting [10 days]	●	11 out of 15	80%
Report turnaround: time taken for management response to draft report [15 days]	●	10 out of 13	80%
Report turnaround: time from management response to issue of final report [10 days]	●	9 out of 9	80%

Key:

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

7. Recommendation

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

Appendix A: Progress against 2025/26 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Risk Management and Assurance	Final report	Reasonable	The review continued to identify effective arrangements for managing and reporting risks, while highlighting opportunities to update documentation, strengthen action tracking, and further align risk reporting with strategic objectives.	April 2026
Welsh Language Standards	Final report	Reasonable	The audit highlighting positive foundations for compliance with the Standards but identified weaknesses in monitoring, oversight, governance attendance, complaints recording, and the need for clearer structured accountability.	April 2026
Follow Up	In progress	See section 4. A sample of closed recommendations will be validated on a rolling basis, with updates provided at each Audit, Risk and Assurance Committee meeting and a summary report prepared at year-end to capture the overall status.		June 2026
Budget Setting	Final report	Reasonable	Strengthening contingency oversight, budget-holder financial skills, and formal accountability arrangements will reinforce the Trust's budget-setting process and support financial resilience in an increasingly challenging environment.	March 2026
Clinical Equipment	Final report	Reasonable	The Trust has made notable progress in clinical equipment safety and management. Further improvements in inventory tracking, maintenance records, and incident reporting will enhance assurance and operational effectiveness.	December 2025
Clinical Model Transformation Programme Management	Final report	Reasonable	Strengthening benefits measurement, dependency mapping, and milestone visibility will enhance assurance over CMTP delivery, supporting clearer impact demonstration and more consistent programme oversight.	March 2026
Integrated Medium Term Plan (IMTP)	Final report	Substantial	Strengthening prioritisation tracking, project framework use, and timeline clarity will further enhance IMTP delivery, supporting resilience and	December 2025

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Development Process			adaptability amid organisational change and resource pressures.	
Cymru High Acuity Response Unit (CHARU)	Final report	Reasonable	Strengthening training oversight, establishing structured benefits evaluation, and ensuring frontline representation in governance will enhance assurance over CHARU's clinical impact and support more consistent, evidence-driven service development.	March 2026
Remote Clinical Support	*See section 3 – Audit deferred at the request of management. This has been replaced with an audit of the Clinical Prioritisation and Assessment Software (CPAS) Group.*			
Clinical Prioritisation and Assessment Software (CPAS) Group	In progress			June 2026
Manchester Arena Inquiry	Final report	Substantial	The Trust demonstrated strong governance and proactive implementation of Manchester Arena Inquiry recommendations. One issue was noted, not all staff received training via Mandatory In-Service Training (MIST) days due to non-attendance.	September 2025
Capacity Management Plan	Final report	Reasonable	The review identified generally robust arrangements for managing non-emergency transport demand, while highlighting weaknesses in documenting decisions, monitoring eligibility and appeals, recording training, and assessing patient impact during capacity pressures.	April 2026
High Risk Record Policy	In progress			June 2026
Data management practices / Devolved data	Draft report	Reasonable	Strengthening organisation-wide data standards, central oversight, and consistent validation processes will improve the quality, consistency, and reliability of devolved reporting, supporting robust decision-making and safeguarding the Trust's data governance arrangements.	June 2026
Emerging technology	In progress			June 2026

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
adoption				
Business Continuity	Draft report	Reasonable	Strengthening ICT continuity planning, consolidating disaster recovery arrangements, and improving Trust-wide oversight and testing of business continuity processes will enhance digital resilience and assurance during system disruption.	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)	Final report	Reasonable	MIST Days achieved strong attendance and compliance rates, supporting staff development. Continued improvements in guidance, oversight, and platform integration will enhance training effectiveness and ensure sustained workforce readiness. Broader CPD hour recording remains an area for improvement.	December 2025
Job Evaluation	Final report	Reasonable	The review identified generally effective processes alongside weaknesses in documentation quality, practitioner capacity, training, and performance oversight, requiring targeted improvement to strengthen consistency, resilience, and transparency.	April 2026
Ambulance Replacement Programme	In progress			June 2026
Fire Safety	Draft report	Limited	The review identified strengthened governance and central oversight, but highlighted weaknesses in local implementation, policy currency, evacuation signage, training coverage, record-keeping, and consistency of fire safety practices across Trust premises.	June 2026

[1] May be subject to change

Appendix B: Follow Up of Internal Audit Recommendations

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

Report Title	Recommendation reference & detail		Priority rating	Internal Audit Assessment
Reasonable Assurance Reports				
Speaking Up Safely (April 2025)	5	Triangulation of concerns data – difficulty in identifying themes/trends and feed learning back to directorates.	High	Appropriately classified as closed.
Seasonal Modelling & Forecasting (May 2025)	6	Oversight of forecasting and modelling activity - lack of clear onward reporting from the Forecasting & Modelling Group and the extent of oversight within the broader Trust governance framework could not be easily demonstrated.	Medium	Additional information required [1].

[1] Whilst we have confirmed that AAA reporting is now embedded as a standard output of the Forecasting & Modelling Group, evidence of formal reporting on Winter forecasting into the Operations Senior Leadership team has not yet been provided.

Table 2: Sample of closed recommendations as at 30 September 2025 (carried over from third review).

Report Title	Recommendation reference & detail		Priority rating	Internal Audit Assessment
Reasonable Assurance Reports				
Data Quality (October 2024)	3.1	Incomplete Information Asset Register.	High	Appropriately classified as closed [2].
Emergency Nurse Communications System Implementation (May 2025)	2	ECNS Audit Arrangements – capacity constraints within the Professional Practice Education (PPE) team.	High	Appropriately classified as closed.

[2] An Information Asset Owners (IAO) Group has been established and is responsible for the development and ongoing maintenance of the Trust's Information Asset Register (IAR). We have confirmed that the IAO Group is in place and has commenced its review of the IAR; however, completing a comprehensive review of all detailed information will take time.

Table 3: Sample of closed recommendations as at 31 May 2025 (carried over from second review).

Report Title	Recommendation reference & detail		Priority rating	Internal Audit Assessment
Reasonable Assurance Reports				
Emergency Nurse Communications System Implementation (May 2025)	8	Actions to address non-compliance rates – actions not captured formally with associated timescales and leads.	Medium	Additional information required.
Public Engagement and Community Involvement (November 2024)	3.3	Regular review of survey questions and responses – formal mechanism to confirm that services have reviewed feedback and provide an update on the action taken.	Medium	Appropriately classified as closed.

Risk Management & Board Assurance Framework

Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust

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Review Reference	WAST-2526-01
Fieldwork	February 2026
Executive Sign Off	7 April 2026
Audit, Risk and Assurance Committee	April 2026
Executive Lead	Trish Mills, Director of Corporate Governance
Audit Team	Osian Lloyd, Head of Internal Audit Felicity Quance, Deputy Head of Internal Audit

Executive Summary

Purpose

The purpose of this review was to assess the effectiveness of the procedures for identification, management and reporting of strategic and key operational risk through the Board Assurance Framework and the Corporate Risk Register.

Overview

The Trust's principal risks are set out in its Corporate Risk Register (CRR), which is often also referred to as the Board Assurance Framework (BAF). These risks are reviewed and monitored by the Board, its committees, and the Executive Leadership Team (ELT). Directorate and local risk registers operate alongside the CRR/BAF, with escalation routes in place where local risks require corporate-level consideration. The Audit, Risk and Assurance Committee (ARAC) retains oversight of the risk management process.

The Trust's Risk Management Transformation Programme (2021–24) has concluded; however, work to strengthen and modernise the BAF is ongoing. Internal Audit and Audit Wales have previously highlighted that the BAF has tended to focus primarily on corporate risks, rather than the broader strategic risks linked to the Trust's long-term objectives, limiting its effectiveness in supporting strategic oversight. To improve its approach, the Trust commissioned external consultants (BDO LLP) in early 2024 to provide best practice guidance for developing a more strategic BAF. Despite the need for stronger alignment to strategic objectives, the BAF nevertheless provides good coverage of the Trust's principal risks and reflects regular review of controls and gaps in assurance. We note that there have recently been more changes to risk scores, having previously reported limited changes even where reasonable progress had been made on mitigating actions.

Wider governance work is currently being undertaken with the Good Governance Institute which is likely to result in changes to existing governance structures and processes. Over the course of the last year, the Board has approved a suite of Risk Appetite Statements, finalised at the Board Development Day in September 2025 following prior consideration by internal committees. Seven statements have been developed and aligned to the Trust six strategic objectives as outlined in the Long-Term Strategy: *Delivering Excellence 2030*. Their development involved articulating risk appetite definitions, agreeing narrative, as well as determining the appetite level against each strategic objective. At present, only two principal risks for the Trust have a risk appetite applied to them and formally reported; however, all principal risks have been mapped to their appetite which we are advised has been shared informally with the ELT.

Progress in developing a strategic BAF has been constrained by previously limited visibility of progress against strategic objectives, particularly at directorate IMTP level, which reduced clarity over strategic risks. Management advises that this position is improving, with the current IMTP explicitly aligned to strategic objectives, providing clearer expected outcomes and a stronger foundation for the continued development and maturity of the strategic BAF. Additionally, a fit for purpose Enterprise Risk Management (ERM) system capable of linking risks across corporate and directorate functions to strategic objectives is in development. Although the Trust had planned to introduce a revised digital BAF by now, no suitable external automated solution was identified, and the Trust is taking forward an in-house solution, which is hoped to be operational by the summer. A new strategic BAF template has been approved by the ARAC, and the first of the strategic risks is being worked up using the new template. The Trust's intention to begin updating its Long-Term Strategy during 2026–27 provides a timely opportunity to align the maturing strategic BAF with any refreshed strategic objectives.

Non-Executive Directors were broadly positive about the Trust's direction of travel and the support provided by the Corporate Governance team. However, they raised concerns about duplication of risk reporting across committees and the timeliness of risk updates, with some committees receiving reports where review dates had already lapsed. This was particularly noted at the March 2026 ARAC. Management advised that this reflected a missed ELT review in February 2026 and capacity pressures within the Corporate Governance team. We also note that verbal updates are typically provided and that actions are already underway to address these issues.

Conclusion

We have concluded **reasonable** assurance on this area. Whilst there are some required areas for action, we have not raised a formal finding for all of these as work is already underway or planned by the Trust to address known weaknesses. The matters requiring management attention where we have raised a formal finding are:

- Although the Risk Management Policy has been updated recently, it still contains some inaccuracies. Other supporting documentation has yet to be updated but this will be completed once the new risk management software is in place; and
- While generally review of the actions contained in the BAF/CRR demonstrated sufficient accountability for their completion, a number of actions were either overdue without explanation, had their completion dates pushed back significantly without documented justification, or had no date specified for their completion. In addition, completed actions did not always translate into updated controls or forms of assurance.

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.

	Objectives	Related Findings	Assurance
1	Risk Management and Assurance arrangements are defined within an up-to-date Policy and Framework and associated procedures, aligned to the Trust's objectives and strategic direction.	1	**Reasonable**
2	Processes are in place to support the monitoring and review of principal risks and assurance mechanisms, including the BAF and CRR, across the Trust, including at Committee and Board level.	-	**Reasonable**
3	The BAF aligns to the Trust's strategic objectives, and both the BAF and CRR have considered risk appetite.	-	**Reasonable**
4	Strategic and corporate (principal) risks are regularly reviewed, and processes are in place to support, and evidence changes in risk scores.	-	**Reasonable**
5	Where gaps in control and assurance are identified, action plans that are regularly monitored are in place setting out the work required to close those gaps.	2	**Reasonable**
6	The audit will identify the progress of implementing the internal audit recommendations raised in the 2024/25 audit of Risk Management (WAST-2425-01).	1	**Reasonable**

Findings & Agreed Action Plan

Objective 1: Risk Management and Assurance arrangements are defined within an up-to-date Policy and Framework and associated procedures, aligned to the Trust's objectives and strategic direction.	**Reasonable**

The Trust has an up-to-date Risk Management Policy in place, which was endorsed by the Audit, Risk and Assurance Committee at its March 2026 meeting, ahead of being formally approved by the Board. The most recent updates are to accommodate the changes to the risk appetite statements. However, some areas of the Policy are out of date, including several references to responsibilities previously held by the Assistant Director Leadership Team with regards to risk management, which they no longer undertake. We are advised that these inaccuracies will be addressed as part of the next scheduled update of the Policy.

The Risk Management Guidelines are still in force and date from October 2023. These were reviewed as part of last year's audit and remain unchanged. They will however be updated to reflect changes to the approach once the new in-house risk management software is fully operational.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Updating of Risk Management Documentation and Training** The Trust's Risk Management Policy has recently been updated to accommodate the changes to the risk appetite statements made towards the end of 2025. The Policy was endorsed by the Audit, Risk and Assurance Committee at its meeting in March 2026 ahead of approval by the Board. The Policy does however still have several references to the role of the Assistant Directors Leadership Team in respect of risk management, which is no longer the case. Other risk documentation will be updated once the new risk management software is in place and in line with the project plan for this.	The Risk Management Policy does not accurately reflect the current approach within the Trust.	The Risk Management Policy will be updated to remove the role of the Assistant Director Leadership Team. The Risk Management Guidelines and other supporting documentation will be updated as soon as the new risk software is fully implemented and in line with the project plan. Training on the new software will be provided to key staff to complement the documented guidance.
			Expected Evidence of Implementation: Updated Risk Management Policy and Project Plan
		Medium Priority	**Officer: Julie Boalch, Assistant Director of Corporate Governance & Risk**
	Theme: Policies & Procedures	Control Operation	**Target Implementation Date: April 2026 (updated Risk Management Policy)**

Objective 2: Processes are in place to support the monitoring and review of key risks and assurance mechanisms, including the BAF and CRR, across the Trust, including at Committee and Board level.	**Reasonable**

The Trust's Risk Management Transformation Programme (2021–24) has concluded; however, work to strengthen and modernise the BAF is ongoing. Internal Audit and Audit Wales have previously highlighted that the BAF has tended to focus primarily on corporate/principal risks, rather than the broader strategic risks linked to the Trust's long-term objectives, limiting its effectiveness in supporting strategic oversight. To improve its approach, the Trust commissioned external consultants (BDO LLP) in early 2024 to provide best practice guidance for developing a more strategic BAF. Despite the need for stronger alignment to strategic objectives, the BAF nevertheless provides good coverage of principal risks and reflects regular review of controls and gaps in assurance. We note that there have recently been more changes to risk scores, having previously reported limited changes even where reasonable progress had been made on mitigating actions.

The process of undertaking the reviews is dependent on a formal cycle which starts with the Executive Leadership Team (ELT). As a result, risks may not have been formally reviewed for one or two months by the time they are presented to certain committees. As an example, the BAF reported to the March 2026 ARAC included 13 risks, of which all but one had a next review date prior to the date of the ARAC meeting. For five of these risks, the next review date was November 2025. Management advised that this position arose primarily due to the ELT review of risks scheduled for February 2026 not taking place, combined with unplanned absence within the Corporate Governance Team limiting capacity to provide cover. We also acknowledge that verbal updates are usually provided to support the risk reports, and that the formal reporting cycle should ensure that the risks are reviewed seven times within a 12-month period which appears reasonable. We are advised that the reporting cycle is currently under review.

The reporting cycle can also lead to board members receiving the same information at sub committees, which has been distilled from the full report presented at ARAC, with meetings sometimes held only a few days apart. This duplication is currently being addressed through planned changes to Board reporting arrangements. As a result, the current BAF/CRR will no longer be presented in full to the Board; instead, the Trust's highest scoring risks will be incorporated into the Avoidable Harm Report presented at each Board meeting. We understand that the Board will regularly receive the strategic BAF, once developed.

Given that measures are already being undertaken to address these issues, this objective has been assessed as reasonable, and it is not considered necessary to raise a separate finding.

Objective 3: The BAF aligns to the Trust's strategic objectives, and both the BAF and CRR have considered risk appetite. **Reasonable**

The Board began developing the suite of Risk Appetite Statements in February 2025, with the work concluding at the Board Development Day held on 19 September 2025 following prior consideration by internal committees. Seven statements have been developed and aligned to the Trust's six strategic objectives, as outlined in the Long-Term Strategy: *Delivering Excellence 2030*. Their development involved articulating risk appetite definitions, agreeing narrative, as well as determining the appropriate level of appetite against each strategic objective.

The Trust does not yet have a full strategic BAF in place, and the document that is currently presented under this heading is effectively a CRR. At present, only the two principal risks *(#223 The Trust's inability to reach patients in the community and #224 Significant Handover of Care Delays*) have a risk appetite applied to them. However, each of the Trust's principal risks have been mapped to the appetite statements to identify those that are within tolerance and those that are outside tolerance. We are advised that this analysis has been shared informally with the ELT. Additionally, at the end of the BAF is a one-page summary mapping strategic objectives to supporting IMTP objectives, with principal risks aligned to each objective.

Work is ongoing to develop a full strategic BAF, which to date has been constrained by the lack of a clear, routine view of progress against strategic objectives, particularly through directorate-level IMTP delivery. This has not always provided the consistent line of sight needed for strategic risk articulation. We are advised that this position is improving, with the IMTP this year explicitly developed around deliverables aligned to strategic objectives. This has created greater clarity about expected outcomes and provides a much stronger platform for the ongoing development and maturity of the strategic BAF. The strategic BAF template has been signed off by the ARAC, and the Corporate Governance team have been working with the Director of People and Director of Culture Change to populate this utilising strategic objective two and a newly developed strategic risk.

An in-house electronic risk management solution has been trialled successfully, and approval has now been given for full development of this system, which is anticipated to be completed by the summer. Once in place, the system is intended to support an integrated approach, linking corporate/principal risks to the strategic risks within the BAF, and mapping these to the associated risk appetite levels applied to each strategic objective.

As action is already being taken to address the necessary developments regarding the BAF and the application of risk appetite, we are not raising a finding but have allocated a rating of reasonable to this objective.

Objective 4: Strategic and corporate risks are regularly reviewed, and processes are in place to support, and evidence changes in risk scores.	**Reasonable**

The reporting of the current BAF/CRR to the Board and its sub-committees continues to be regular and comprehensive. There is a formal reporting cycle which ensures that the risks are reviewed and signed off by the ELT before being presented to the Board and relevant sub-committees. A standard Risk Management and Board Assurance Framework report is routinely submitted to the Board, the Audit, Risk and Assurance Committee, and other sub-committees, providing useful narrative on the latest position of each key risk. As referenced elsewhere in this report, the current reporting cycle can at times lead to delays and duplication for individual committees, although action is being taken to address this through the Trust's proposed delivery group structure.

Risks are subject to regular review and update, and the rationale for any change in risk score is documented. The March 2026 Audit, Risk and Assurance Committee papers included a table that provided an audit trail of risk scores for each risk dating back to March 2023 (or from the point the risk was added). Of the 24 risks included, eight remain at the same score as when first added, although two of these had previously increased before reverting to their original score. One risk, cyber security, has increased in score, which is understandable given the sector-wide escalation in cyber threats in recent years. The remaining 15 risks have either reduced in score, been de-escalated, or closed, which appears reasonable based on the evidence reviewed.

Although we are not raising a specific finding for this objective, we have assigned a reasonable rating, reflecting the issues with duplication and delays in the reporting cycle that have been referred to elsewhere in this report.

Objective 5: Where gaps in control and assurance are identified, action plans that are regularly monitored are in place setting out the work required to close those gaps.	**Reasonable**

There is clear evidence of BAF/CRR action plans being updated and reported to every meeting of the Trust Board and its sub-committees. Risks #223 and #224 are now also reported with controls, assurances and any related gaps split between those that are internal and which are within the Trust's gift to control, and those which are external and can only be monitored.

We note the Audit Wales finding in their recent Structured Assessment as follows:

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

The BAF/CRR presented to the March 2026 meeting of the Audit, Risk and Assurance Committee was reviewed to confirm whether gaps in control and/or assurance were supported by up to date and specific action plans. All risks had identified gaps in either controls or assurance, and each had an associated action plan in place to address.

Across the BAF/CRR, there were 55 actions in total, all of which had an assigned owner. Of these:

- 12 actions had been completed.
- 21 actions were on track to be completed by their planned target date.
- 3 actions had no date specified.
- 4 actions were ongoing.
- 2 actions did not have target dates because they were dependent on third party activity.
- 5 actions were overdue; and
- A further 8 actions were potentially overdue, with target dates falling prior to March but after the date on which the actions were last reviewed.

Of the above, nine actions had also seen their completion date revised and pushed back.

Key Findings		Risk & Impact	Agreed Management Action
2	**Completion of Action Plans** While generally the review of the actions contained in the BAF demonstrated sufficient accountability for their completion, a number of actions were either overdue without explanation, or had no date specified for their completion. Additionally, where completion dates had been revised, which in some cases involved pushing the date back by nine months, there was little justification provided for this delay. In a number of cases, it was not always clear whether the action had been completed, and if complete, whether this translated into an additional control or assurance mechanism.	Risks may not be mitigated effectively.	All Action Plans will have a date for completion of the specific action and action owners will be held to account for the completion of the action within the targeted timescales. Where this is not possible, dates will be revised but with clear justification provided. Where actions are completed, consideration will be given as to whether this justifies an additional control or form of assurance. **Expected Evidence of Implementation:** Completed Action Plans.
		Medium Priority	**Officer: Julie Boalch, Assistant Director of Corporate Governance & Risk**
	Theme: Risk Management	Control Operation	**Target Implementation Date: June 2026**

Objective 6: The audit will identify the progress of implementing the internal audit recommendations raised in the 2024/25 audit of Risk Management.	**Reasonable**

As is the case this year, our 2024/25 internal audit report identified a number of required actions, but for which a formal finding was not raised due to the Trust already having plans in place. The one formal agreed action from last year's review was:

"Once new ways of working are finalised and introduced the risk management documentation - Risk Management Policy; Risk Management Guidelines; and the Guidance on Interpreting the Board Assurance Framework will need to be updated and reapproved."

As noted under Objective 1, the Risk Management Policy has been updated; however, some inaccuracies remain and will need to be corrected. The supporting documentation, specifically the Risk Management Guidelines and the Guidance on Interpreting the Board Assurance Framework, has not yet been updated. This work is planned to be completed once the BAF is in place, and the new risk management software is fully operational.

Details of progress on the recommendations outstanding from the 2023/24 report are provided in Appendix A. These relate solely to the development of the risk management software, which is now progressing.

Appendix A Progress with Prior Year Recommendations

Ref	Recommendation	Management Response	Audit Update (March 2025)	Audit Update (March 2026)
3.1	All risks should be uploaded and managed on Datix. **MEDIUM RISK**	Datix is not currently fit for purpose. Therefore, agreeing that all risks should be uploaded and managed on Datix is not possible at this time. What is accepted is that there should be an agreed approach within local and directorate risk registers i.e. either all on Datix and managed there with appropriate reporting, or outside of Datix with an audit trail of identification, development, review, escalation, and closure. **31 January 2025**	Progress on procurement of a new Risk Management system is underway in consultation with the Director of Digital. **ONGOING**	Approval has been given for the development of an in-house software package which is anticipated to be fully operational by the summer of 2026. **ONGOING**
4.1	We recommend the Trust consider arrangements to support the consistency and monitor the completeness of directorate registers. **MEDIUM RISK**	The risk team will work with the clinical and operations team and either develop a plan to manage these risks externally to Datix but with an appropriate audit trail whilst an electronic risk management system is procured, or to use Datix for the capture of the operations and clinical risks. **31 October 2024**	As stated above, not everyone uses Datix, but there is evidence that risks are being reviewed on a regular basis. The acquisition of the risk management software referred to above should provide a complete and consistent platform for all risks to be recorded. **ONGOING**	As before and above, the development of the risk management software should facilitate a consistent approach to the recording and reporting of risk at all levels of the Trust. **ONGOING**

Appendix B Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Prioritisation of Findings

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

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

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

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

Public Sector Internal Audit Standards

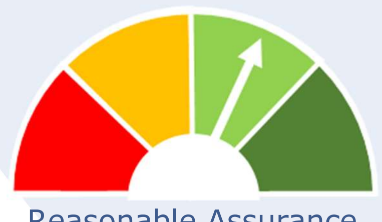
Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute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

Welsh Language Standards

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust



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Fieldwork	October 2025 - February 2026
Executive Sign Off	13 March 2026
Audit Committee	28 April 2026
Executive Lead	Trish Mills, Executive Director of Corporate Governance
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

Executive Summary

Purpose

To provide assurance on the adequacy and effectiveness of the arrangements in place to comply with the requirements of the Welsh Language Standards.

Overview

The Welsh Language (Wales) Measure 2011 establishes a legal framework that places a statutory duty on the Welsh Ambulance Services University NHS Trust (the Trust), and other public bodies, to comply with the Welsh Language Standards. These Standards aim to strengthen the use of the Welsh language in public services, enhancing both the quality and accessibility of services delivered in Welsh.

The Measure is underpinned by two key principles:

- The Welsh Language should be treated no less favourably that the English language in Wales; and
- People in Wales should be able to live their lives through the medium Welsh if they choose to do so.

On 30 May 2019, the Trust transitioned from implementing its Welsh Language Scheme under the Welsh Language Act 1993 to adopting the Welsh Language Standards introduced by 2011 Measure. From that date, new statutory requirements came into effect across Wales, with all public sector organisations receiving Compliance Notices outlining the specific Standards applicable to them. The Trust's Compliance Notice identified 114 Standards that it must meet.

We have concluded **reasonable assurance** in this area. The Trust has established positive foundations to support compliance with the Welsh Language Standards. There is clear leadership in place, supported by a comprehensive Welsh Language Policy and practical guidance that promotes consistent bilingual practice across the organisation. Staff engagement is strengthened through initiatives such as the Welsh Language Network and targeted training opportunities, and the Trust continues to meet statutory reporting requirements. Evidence of compliance is evident across key Service Delivery Standards.

Despite these strengths, we identified areas requiring improvement to ensure the Standards are fully embedded and subject to effective oversight. The matters requiring management attention include:

- Insufficient evidence of ongoing monitoring and embedding of compliance arrangements.
- Absence of a structured framework for oversight, accountability and assurance for the Standards.
- Governance weaknesses within the Welsh Language Advisory Group, including repeated non-quoracy and inconsistent attendance.
- Inconsistent recording and escalation of Welsh-language-related complaints.

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

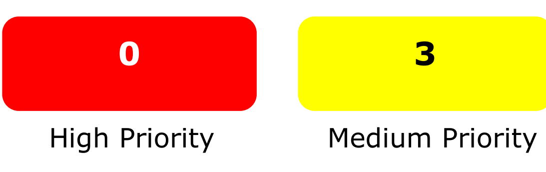
For management information, we have also highlighted the absence of formal arrangements to address the persistent non-compliance with Welsh Language Awareness mandatory training. No separate finding has been raised, as this issue aligns with an existing recommendation in our Mandatory In-Service Training Report (issued November 2025: reasonable assurance).

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	To assess whether clear leadership and accountability structures are in place for Welsh Language Standards compliance.	2	**Reasonable**
2	To determine if up-to-date policies and procedures support consistent application of the Standards.	-	**Substantial**
3	To evaluate whether staff are sufficiently informed and trained to meet their Welsh language obligations.	-	**Reasonable**

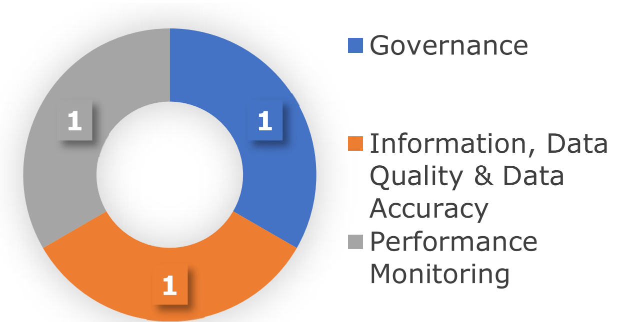
4	To review whether services are delivered in a way that meets the Standards and ensures equitable access in Welsh.	1	**Reasonable**
5	To confirm that effective mechanisms exist to monitor compliance and report on performance.	2	**Reasonable**
6	To check whether complaints and feedback related to Welsh language provision are managed and used to improve services.	3	**Reasonable**

Management Actions



High Priority Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

At a Glance: Welsh Language Skills across the Workforce [1]

[1] Data extracted from the Trust's Welsh Language Standards Annual Report 2024/25

Table 1: Welsh Language Skills of Staff Profile – Listening/Speaking

0 No Skills	1 Entry	2 Foundation	3 Intermediate	4 Higher	5 Proficiency	Unknown	Total
2,414	816	280	169	170	401	178	**4,428**

Table 2: Welsh Language Proficiency per Directorate

Directorate	Intermediate	Higher	Proficiency
Chief Executive	1	1	0
Corporate Governance	0	0	2
Digital	1	1	6
Finance & Corporate Resources	1	7	11
Clinical	1	2	7
Operations	153	151	356
Partnerships & Engagement	0	2	0
People & Culture	4	2	8
Quality, Safety & Patient Experience	8	4	10
Strategy, Planning & Performance	0	0	1
Total	**169**	**170**	**401**

Findings & Agreed Action Plan

Objective 1: To assess whether clear leadership and accountability structures are in place for Welsh Language Standards compliance.	**Reasonable**

The Trust's Welsh Language Standards Report (2024/25) details the Welsh language leads and champions. The Director of Corporate Governance/Board Secretary is the Executive Lead, and there is a Non-Executive Director Welsh Language Champion involved in promoting the use of Welsh Language both internally and externally.

Operationally, the Welsh Language Services Manager reports to the Head of Compliance & Assurance and is supported by a Welsh Language Translation Officer. While there is no wider Welsh Language Team within the organisation, recent structural changes have introduced administrative support, strengthen the capacity of the service.

The Welsh Language Advisory Group (WLAG) operates to provide oversight, support and monitoring of compliance with the Standards, the Welsh Government's 'More Than Just Words' (MTJW) Framework, and any emerging Welsh language requirements. Reference should be made to Objective 5 for our assessment of the effectiveness of this governance structure.

We were advised that the Trust intends to develop a network of Welsh Language Champions across the organisation to support and promote Welsh language activity at locality level. As this has not yet been implemented, a Welsh Language Network (WLN) was established in July 2025 to help fill this gap. The WLN is an open and inclusive forum, available to all staff who wish to support the use and development of the Welsh language and its culture within the Trust. It operates as a Microsoft Teams channel rather than a formal group and currently has 56 subscribed members.

The Welsh Government's MTJW programme aims to ensure that Welsh speakers can access health and social care in their preferred language by embedding Welsh language provision as a routine and integral part of service delivery. To support this aim, the Welsh Government has issued a five-year action plan consisting of 38 actions for which each Health Board and Trust in Wales is accountable. The Trust has submitted an annual response, as required, outlining its position and progress against each action. These responses are appended to the Welsh Language Standards Annual Report (2024/25). No formal feedback on the Trust's action plan has been received to date.

Objective 2: To determine if up-to-date policies and procedures support consistent application of the Standards.	**Substantial**

Standard 79 (Operational Standard) of the Compliance Notice requires the Trust to "*develop a policy on using Welsh internally for the purpose of promoting and facilitating the use of the language, and publish that policy on its intranet*." While the Standard does not prescribe specific content requirements, the Trust's Welsh Language Policy (updated in 2024) is appropriately aligned with the overarching thematic areas set out across the 114 applicable Standards: Service Delivery, Policy Making, Operations, and Record Keeping.

The policy contains the expected core components—Roles and Responsibilities, Training, and Impact Assessments—consistent with the Trusts' standard policy structure. It also includes a dedicated section on Communication and Engagement (6.6.1), which outlines the Trust's intention to embed the Welsh language as a normalised and integral part of organisational culture. This approach positions Welsh as a natural part of the organisation's identity, rather than being viewed solely through a compliance lens. This is reinforced through initiatives such as bilingual branding, awareness-raising campaigns, visible bilingualism at internal events, and encouraging staff to adopt basic "linguistic courtesy".

A comparison with policy documents from other NHS Wales organisations found the Trust's policy to be notably more comprehensive and strategically focussed. One comparator policy functioned largely as a procedural guide; while another focussed mainly on compliance from a patient-facing perspective. To further support the practical application of the Standards, the Trust provides a range of supplementary guidance designed to help staff engage with and improve their Welsh language skills, including:

- Quick guides for events, telephone calls, and meetings.
- Welsh Language Courtesy Skills – a series of Trust-produced YouTube videos offering support with the pronunciation of greetings, place names, numbers, and common names.
- Guidance on bilingual email signatures.

Section 6.3.3 of the Welsh Language Policy sets out the Trust's arrangements for dealing with complaints received, as per Standards 83-85. This is further complemented by the Trust's Putting Things Right Policy (Section 8). Monitoring and reporting of complaints are further considered under *objective 6*.

In addition, section 11 of the policy outlines the Trust's arrangements for monitoring overall compliance. The WLAG is responsible for overseeing performance, promoting good practice, and tracking key indicators through its quarterly meetings. Further commentary on these governance arrangements is provided under Objectives 4 and 5.

Objective 3: To evaluate whether staff are sufficiently informed and trained to meet their Welsh language obligations. **Reasonable**

In line with NHS Wales Statutory and Mandatory Training requirements, all Trust staff are required to complete Welsh Language Awareness (WLA) training on a three-year cyclical basis (commencing 1 April 2023). The Trust Board and its Board-level Committees receive the Monthly Integrated Quality and Performance Report (MIQPR), which includes data on Trust-wide compliance against the Welsh Government target of 85% for all statutory and mandatory training.

As at 9 January 2026, WLA compliance (as recorded on ESR) was 78.55%, with more than 20% of operational staff yet to complete the course. We were informed that even if all nine remaining service areas within the Trust were to achieve 100% compliance, overall compliance would only increase marginally to 79.54%.

Our recent Mandatory In-Service Training report (issued December 2025: reasonable assurance) highlighted weaknesses in accountability structures for monitoring and addressing individual non-compliance, with no formal arrangements for managing persistent cases. As this matter is being monitored through the Trust's internal audit recommendation tracker, we have not sought to replicate the recommendation in this report.

For non-Welsh speaking staff, the Trust offers Welsh taster sessions providing introductory Level 1 support. Additional beginner-level Welsh language courses have recently been made available through the National Centre for Learning Welsh, aligned to the Welsh Government's *More than Just Words* (Mwy na Geiriau) strategy, which aims for all health and social care staff to reach courtesy-level Welsh by 2027.

During 2025/26, a new training course—*Welsh in an Emergency: Essential Welsh for Paramedics / Emergency Medical Technicians / Emergency Ambulance Practitioners*—was developed specifically for Emergency Medical Services (EMS) staff. The programme consists of ten weekly one-hour tutor-led sessions aimed at beginners and focuses on improving communication with patients and families through basic conversation, commands, clinical scenarios, and anatomical terminology. It was advertised on Learn365, the Trusts' training platform, and staff were required to register their interest due to limited capacity (12 places per cohort). More than 50 expressions of interest were received; however, rota constraints meant only eight staff were able to attend. Whilst positive feedback was shared with the course provider, we note the challenges in offering training that EMS staff can consistently attend, given the varying rota patterns across localities. The Trust has not yet determined next steps, whether to continue offering the course despite attendance difficulties, or to provide progression opportunities for those who completed the initial programme.

Standards 96 and 116 (Operational Standards) require the Trust to assess and record employees' Welsh language skills, with performance reported annually through the Welsh Language Annual Report (refer to At A Glance, page 3). This information is captured within ESR (Electronic Staff Record), and completion of the self-assessment is the responsibility of each employee. As of 31 March 2025, approximately 96% of staff had recorded their Welsh language skills, compared with 91.5% in the previous year.

Objective 4: To review whether services are delivered in a way that meets the Standards and ensures equitable access in Welsh.	**Reasonable**

A Welsh Language Standards (WLS) tracker is maintained by the Welsh Language Manager, outlining each applicable Standard and the current status of compliance. Of the 59 Service Delivery Standards, the status at the last date of update (20 October 2025) was reported as Complete: 41 Standards; Partly Met: 14 Standards; Not Met: 1 Standard; Not Applicable: 3 Standards.

While the tracker provides a useful position statement, it does not include an audit trail to evidence when individual Standards were implemented. As a result, we were unable assess the timeliness or progression of compliance activity. In addition, our review of a sample of five Standards marked as complete confirmed that arrangements were in place to meet the specified requirements; however, there was limited evidence of ongoing monitoring to demonstrate continued compliance or the sustained embedding of these arrangements.

The Welsh Language Manager advised that the WLS tracker is a working document and has not been formally presented to any governance forum. Although the Welsh Language Annual Report provides narrative updates each year against the categories of the Standards, it does not clearly identify which Standards remain non-compliant or only partially met. This reduces transparency and limits oversight of outstanding actions (see **Key Finding 1**).

In 2024/25, the Trust established a Welsh Language Standards Compliance Baseline across four areas: Correspondence (Standards 1 & 4-7); Document Publication (Standards 36-38); Signage (Standards 47-49); and Reception Services (Standards 50-53). Compliance was assessed through Translation Service audits and a Trust-wide self-assessment survey conducted in April 2025. This identified compliance in the first three areas, while Reception Services were highlighted as requiring further improvement. This work has been carried forward into 2025/26, with additional audits and spot checks planned to support continuous improvement.

Standard 110 requires the Trust to develop and publish a five-year plan setting out: (a) the extent to which it is able to offer clinical consultations in Welsh; (b) the actions it intends to take to increase its ability to do so; and (c) the timetable for delivering those actions. The Trust published its plan for the 2019–2024. However, Standard 110A requires the Trust to assess compliance with that plan and publish the assessment within six months. The Trust has not met the requirement under 110A, and limited work was undertaken on the five-year plan until 2024/25. (**See Key Finding 1**).

Historically, the Trust has highlighted challenges in meeting the Telephone Call Standards (8-20) for 111 call handling. Performance increased from 18.1% in 2022/23 to 45.5% in 2023/24 and remained stable at 45.7% for 2024/25. This sits alongside low Welsh-language demand, with Welsh calls representing just over 1% of all 111 calls. Following discussions with the Office of the Welsh Language Commissioner and recognising the complexities of delivering Welsh-language clinical consultations through the 111 service, the Trust has now committed to developing and finalising a revised plan during 2026–27.

Consideration of Standard 107A (operational standard covering publication of application forms, job information and interview materials) has been undertaken separately as part of our Job Evaluation audit, with any findings to be reported within that report.

In December 2025, the Welsh Language Commissioner required the Trust to complete a self-assessment of its compliance with the Standards, rating assurance levels from no assurance to high assurance and providing justification and planned actions for any Standard not rated high. Of the 56 statements responded to, the Trust assessed 25 as High Assurance; 15 as Medium Assurance; 7 as Low Assurance; 2 a No Assurance; and 7 as Not Applicable. The assessment was submitted in January 2026, with feedback outstanding at the time of reporting. We were advised that, because the self-assessment represented a broader organisational review, limited progress was made against the 2024/25 baseline improvement actions. These actions are now expected to be incorporated into a wider organisational compliance plan for 2026/27 once the Commissioner's feedback is received.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Insufficient Oversight and Monitoring of Welsh Language Standards Compliance** There is insufficient evidence that Welsh Language Standards compliance arrangements are consistently embedded, monitored, or subject to effective oversight across the Trust. Sample testing of five Standards marked as completed confirmed that initial arrangements had been established; however, there was limited evidence of ongoing monitoring to demonstrate continued implementation within service delivery. The Trust did not meet the requirements of Standard 110A, having failed to assess and publish its compliance with the 2019–2024 five-year plan within the required timeframe. Work to refresh the plan for 2026–27 has only recently commenced. There is an absence of a structured framework to support systematic monitoring, accountability, or assurance. The compliance tracker, covering all 114 applicable Standards, lacks core governance elements such as responsible owners, implementation timelines, or defined monitoring arrangements. Oversight of standards compliance has rested solely with the Welsh Language Manager since his appointment in 2018, creating a single point of dependency and limiting organisational ownership of compliance. We acknowledge, however, that revised arrangements are planned for implementation from 2026.	Weak oversight and monitoring increase the risk of continued non-compliance with Welsh Language Standards, potentially resulting in regulatory challenge, reputational harm, and reduced assurance that Welsh-language services are delivered consistently across the Trust.	**Agreed Action:** 1.1 WLS Compliance Tracker has been updated. **Complete** 1.2 (Std 110) 5-Year Clinical Consultation Plan 2026-2031 ~ regular reporting from Welsh Language Advisory Group (WLAG) to the Equality Diversity and Inclusion (EDI) Steering Group, then on to Executive Leadership Team (ELT). 1.3 Reporting and monitoring ~ Regular reporting from the Welsh Language Advisory Group (WLAG) to the Equality, Diversity and Inclusion (EDI) Steering Group, then on to the Executive Leadership Team (ELT). **Expected Evidence of Implementation:** • Copy of revised tracker with assigned leads for actions and dated reviews (1.1) - **Complete** • Copy of published 5-year Clinical Consultation Plan 2026-2031 (1.2) • WLAG and EDI Steering Group AAA report for three cycles of business. (1.3)
		Medium Priority	**Officer:** Melfyn Hughes (Welsh Language Services Manager) **Target Implementation Date:** (1.1) Already completed March 2026; (1.2) & (1.3) August 2026
	Theme: Performance Monitoring	Control Operation	

Objective 5: To provide an assurance on the arrangements in place to comply with the requirements of the Standards.	**Reasonable**

A governance framework is in place to support compliance with the Welsh Language Standards and to ensure statutory reporting requirements are met. Key elements include:

- Welsh Language Advisory Group (WLAG): Provides, oversight, support and monitoring of compliance with the Standards, the MTJW Framework, and emerging Welsh language requirements
- Equality, Diversity Inclusion (EDI) Steering Group: Ensures alignment between the Welsh Language Standards and the Strategic Equality Plan.
- Executive Leadership Team (ELT): Drives culture change and organisational commitment to Welsh language compliance.
- People & Culture Committee (PCC): Provides Board-level assurance that the Trust is discharging its statutory Welsh language obligations.
- Trust Board: Approves the Welsh Language Annual Report and oversees key performance indicators relating to the Welsh language.

The WLAG terms of reference (ToRs), last updated in April 2024 and subject to annual review, specify quarterly meetings or as otherwise directed by the Chair. Review of AAA (Alert, Advise, Assure) reports since July 2024 shows that meetings have occurred on an ad hoc basis, with only five meetings held to date (see **Key Finding 2**). Quoracy was not achieved at three of the last four meetings, largely due to the absence of a Trade Union representative and no deputy attendance recorded. Additionally, defined membership has not been met, including the omission of the Putting Things Right team. Attendance records also show that around a quarter of members routinely do not attend and are not represented by deputies (see **Key Finding 2**).

Review of WLAG agenda items confirmed alignment with the ToRs and the requirements of the Welsh Language Standards (see **Key Finding 1**).

The EDI Steering Group receives AAA Reports summarising WLAG activity, with onward reporting to ELT. Formal Welsh language reports, including the Welsh Language Annual Report and the Strategic Equality Plan Annual Report, are presented to EDI Steering Group prior to ELT consideration. Where formal approval is required, reports are subsequently considered by PCC and the Trust Board. The MIQPR, presented to the Board and its sub-committees, includes Welsh-language-related metrics such as call answering rates, monitored over a 12-month period.

The Trust’s Welsh Language Annual Report, required under Standard 120, was finalised in August 2025 and published within the six-month statutory deadline. Review of reporting since the requirement was introduced in 2019/20 confirms consistent adherence to this timeframe.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Weaknesses in WLAG Terms of Reference and Governance Arrangements** Our review identified several weaknesses in the WLAG Terms of Reference ToR) and their application in practice. Attendance has been inconsistent with several members failing to attend four or more consecutive meetings. This includes the Trade Union representative, whose repeated non-attendance resulted in the group being non-quorate for four consecutive meetings. Approximately a quarter of the membership routinely fail to attend, and deputies are not being nominated in their place. Section 4 of the ToRs sets out the membership requirements. While paragraph 4.1 lists the expected representation, the table at paragraph 4.2 omits a representative from the Putting Things Right team, an omission reflected in AAA reports, which confirm no attendance from this area. Membership should be reviewed to ensure sufficient and appropriate representation across the Trust. In addition, the group is not meeting with the expected quarterly frequency. While the ToR allows for meetings *"as otherwise directed by the Chair"*, the current ad hoc scheduling does not align with the need for regular oversight and reduces assurance over effective monitoring of Welsh Language Standards compliance.	Weaknesses in WLAG membership, attendance, and meeting frequency increase the risk of ineffective oversight of Welsh Language Standards, potentially resulting in gaps in compliance, reduced organisational assurance, and exposure to regulatory or reputational consequences.	**Agreed Action:** 2.1 WLAG Terms of Reference / membership to be reviewed in line with the review of Integrated Governance Structures which will also include the EDI Steering Group. 2.2 Quarterly meeting schedule to be developed, with attendance and deputy arrangements reinforced to ensure quoracy, and attendance routinely monitored and reported.
			Expected Evidence of Implementation: • Copy of revised WLAG ToR and membership list (2.1) • Copy of published WLAG meeting calendar 2026/27 (2.2) • Copies of WLAG AAA reports including record of attendance (2.2)
		Medium Priority	**Officer:** Melfyn Hughes (Welsh Language Services Manager) **Target Implementation Date:** (2.1 & 2.2) June 2026
	Theme: Governance	Control Design	

Objective 6: To check whether complaints and feedback related to Welsh Language provision are managed and used to improve services.	**Reasonable**

The Trust's Welsh Language Policy requires that a record is kept each financial year of all complaints relating to compliance with the Welsh Language Standards, in line with Standard 115. Standard 120 further requires the annual report to include the number of such complaints received during the reporting year.

Our review of Welsh Language Annual Reports from 2019/20 onwards confirmed that the Trust consistently reports formal Welsh language complaints, along with a summary of the Trust's response and any actions taken. The Welsh Language Manager maintains a spreadsheet recording all formal complaints received to date (a total of 19). Review of a sample of three complaints confirmed appropriate evidence was retained to support the actions taken. Whilst some delays were identified in responding to the Welsh Language Commissioner (maximum of three days), these were not considered significant, and the Trust complied with the 20 day-response requirements under the PTR regulations.

We were advised that some Welsh-language-related concerns are resolved quickly and locally without escalation to the Welsh Language Manager, Corporate Governance Team, or the PTR Team. While early local resolution is permitted under both Trust policy and PTR Regulations, the PTR policy also requires such cases to be recorded "on an early resolution form or electronically via the Datix Cymru system to the Putting Things Right Team". The Welsh Language Manager has been made aware of instances where early-resolution complaints were not reported in accordance with this requirement (see **Key Finding 3**).

We have been advised that a formalised complaints-tracking document will be introduced from 2026 to strengthen administrative oversight and monitoring of Welsh language complaints.

Key Findings		Risk & Impact	Agreed Management Action
3	**Inconsistent Recording and Escalation of Welsh Language Complaints** We were advised that some Welsh-language-related complaints are resolved promptly at a local level and are therefore not escalated to the Welsh Language Manager or the Corporate Governance Teams. While both the Trust's Putting Things Right Policy and the wider national PTR regulations permit early or local resolution through informal management, they also require all such cases to be formally recorded, either via and early resolution form or through the Trust's incident management system (Datix), to ensure a complete and accurate record of complaints. Although the overall number of Welsh language complaints remains low (19 since the implementation of the Standards), incomplete reporting limits the Trust's ability to assess complaints consistently, identify of themes and trends, and take proactive action to prevent recurrence. Failure to capture all	Failure to consistently record and escalate Welsh language complaints increases the risk of incomplete assurance, missed themes or trends, and inaccurate reporting within the Welsh Language Standards Annual Report.	**Agreed Action:** 3.1 Process to be agreed between the Corporate Governance, Operations and QSPE (PTR Team) to ensure that all Welsh language complaints received (even those resolved locally) are reported and recorded on Datix. 3.2 Welsh language complaints are reported within the **Welsh Language Annual Report**; however, the narrative within the report should be further developed to provide greater insight into themes, organisational learning and any service improvements arising from complaints. **Expected Evidence of Implementation:** • Confirmation of the agreed tripartite process between Corporate Governance, Operations, and QSPE (PTR Team) Directorates (3.1)

Key Findings	Risk & Impact	Agreed Management Action
complaints also risks incomplete disclosure within the Welsh Language Annual Report.		• Copy of 2025/26 Welsh Language Annual Report containing reporting on Welsh language related complaints and any learning identified (3.2)
	Medium Priority	**Officer:** Melfyn Hughes (Welsh Language Services Manager) **Target Implementation Date:** June 2026
Theme: Information, Data Quality & Data Accuracy	Control Operation	

Appendix A: Assurance Opinion and Prioritisation of Findings

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

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

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

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Capacity Management Plan

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust

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Fieldwork	January - March 2026
Executive Sign Off	16 April 2026
Audit Committee	28 April 2026
Executive Lead	Lee Brooks, Executive Director of Operations
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

Executive Summary

Purpose

To provide assurance that the Capacity Management Plan (CMP) is being applied appropriately, with consistent decision-making and clear communication of outcomes to patients.

Overview

Non-Emergency Patient Transport Services (NEPTS) provide essential transport for individuals across Wales who are unable, for medical reasons, to travel independently to and from healthcare appointments at clinics, hospitals, and day centres.

Eligibility is determined through a Patient Needs Assessment (PNA) conducted by NEPTS, in accordance with criteria set out by Welsh Government guidance (Welsh Health Circular 2007/005). The CMP is designed to be activated when demand exceeds available capacity; however, as has been widely reported in the Trust, these circumstances occur on a regular basis. As a result, the CMP continues to present considerable operational challenges, with an average of 500 journeys across Wales cancelled each week due to demand exceeding available capacity. As a consequence, patients who would ordinarily be eligible for transport under the WHC are often advised that transport cannot be provided.

The CMP establishes a structured framework for NEPTS to respond effectively when demand pressures arise. In light of increasing demand for NEPTS, the Trust has revised the CMP to enhance its ability to manage journey requests and ensure that eligible patients are appropriately prioritised.

Audit Opinion

We have concluded **reasonable** assurance on this area. The Trust has established a strong foundation of controls to support the appropriate application of the CMP. Clear and comprehensive guidance is in place to direct the management of non-emergency patient transport requests and the operation of the CMP. This is supported by a well-structured training programme that combines classroom-based learning, system-specific instruction, supervised practice and ongoing support to ensure staff are equipped to perform their roles effectively.

System-driven controls at the booking stage are in place with the embedded PNA ensuring eligibility decisions are made consistently and in accordance with defined criteria. Standardised scripts are used to ensure transparency and clarity for patients when communicating eligibility outcomes, with a review process in place should decisions be challenged.

The Trust has established arrangements for capturing and analysing NEPTS performance information. The Cleric system is used to record core datasets, and a well-developed Power BI dashboard that enables detailed trend analysis, supports informed operational oversight, and strengthens assurance over CMP activity. In consideration of this data, the Trust may benefit from reviewing its booking methodology, with consideration given to basing bookings on capacity available at the time of the journey requirement rather than two days in advance.

The matters requiring management attention include:

- The CMP could be strengthened by further clarifying key activation triggers, cancellation criteria and prioritisation rules, including the use of more measurable thresholds.
- There is no central repository to record and retain training records.
- NEPTS does not record or monitor ineligible PNA outcomes, limiting visibility of refusals, trends, and unmet need.
- The Cleric system does not provide functionality to record the rationale for journey-planning decisions and CMP activation, limiting the audit trail and reducing transparency of prioritisation decisions.
- Eligibility appeals are not tracked or analysed, resulting in limited oversight of trends, outcomes and areas for learning and process improvement.
- There is no systematic method for capturing patient-reported impacts, creating a gap in understanding the real-world consequences of cancellations.

We note that a separate journey booking process used by healthcare professionals operates differently from the standard patient-initiated pathway. As the majority of these bookings are not normally subject to CMP cancellation procedures, we have not reviewed this process as part of the audit.

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.

	Objectives	Related Findings	Assurance
1	There is clear and documented guidance in place regarding the management of non-emergency patient transport requests, and application of the Capacity Management Plan.	3	**Reasonable**
2	Appropriate training is provided to staff responsible for processing transport requests.	1	**Reasonable**
3	The Capacity Management Plan is implemented consistently, and decisions relating to transport requests are made in accordance with established procedures.	2,3,4	**Limited**
4	Decisions are communicated effectively to patients and/or their representatives; with a defined process for patients to request a review of eligibility where transport requests have been declined.	4,5	**Reasonable**
5	Mechanisms are in place to capture and analyse performance information, such as journey cancellations, and to evaluate the impact of these on patients and their care, with reporting to appropriate forums both internally and externally.	4,6	**Reasonable**

At a Glance – Non-Emergency Patient Transport Services Activity

NEPTS Activity Overview

The following table sets out the scale of NEPTS activity [1] and the pressure on capacity, highlighting the volume of journeys that cannot be delivered and are therefore cancelled under the Capacity Management Plan (CMP).

Metric	October 2025	November 2025	December 2025
Total Journeys booked [2]	66,751	61,402	70,086
Total Journeys completed [2]	57,728	53,219	55,452
Total cancellations (all causes [3], excluding CMP)	6,336	5,581	12,514
CMP cancellations	2,687	2,602	2,120
% of demand	4.03%	4.24%	3.02%
Average journeys cancelled per week under CMP	607	607	488

[1] This data has been extracted from a Cleric system report that includes all NEPTS activity during the period October to December 2025

[2] The values presented reflect the total number of NEPTS journeys, with each individual movement counted separately. This means that an inward journey and an outward journey are recorded as two distinct journeys (noting that the majority of bookings involve transporting a patient both to and from their appointment). Consequently, where transport is cancelled under the Capacity Management Plan (CMP), both legs of the journey are recorded as separate cancellations. This approach provides an accurate representation of overall service activity and the scale of capacity pressures experienced across the system.

[3] Other cancellation causes (as per Cleric) include, but are not limited to, cancellation by family/friend/patient; patient is deceased; patient has Covid-19; patient is in hospital; patient has access to own transport; treatment has finished early; poor weather conditions; and bank holiday suspensions.

Capacity Management Plan Activation Frequency

The following table sets out the number of days that the Capacity Management Plan (CMP) was activated [1].

Month	Days in month (Monday - Friday)	Days that the CMP was activated
October 2025	23	23
November 2025	20	20
December 2025	23	22

Findings & Agreed Action Plan

Objective 1: There is clear and documented guidance in place regarding the management of non-emergency patient transport requests, and application of the Capacity Management Plan.	**Reasonable**

The Trust's Capacity Management Plan (CMP) is a comprehensive and well-documented framework governing the management of non-emergency patient transport during periods of operational pressure. The approved CMP (last reviewed May 2023) sets out clear eligibility and prioritisation criteria, defined booking processes, and an established decision review mechanism (see Appendix A). The CMP is aligned with the statutory eligibility requirements set out in WHC (2007) 005 through the Patient Needs Assessment (PNA) process. Although England updated its equivalent criteria in 2022, the Welsh eligibility criteria has not been reviewed as originally intended (12 months post publication as cited in the circular). We recognise that responsibility for undertaking this review sits outside the Trust.

While several operational thresholds are clearly defined within the CMP, such as the booking cut-off time, communication requirements, and approval steps for cancellation categories, key elements would benefit from the inclusion of more measurable and objective triggers. It is recognised that some flexibility is necessary to ensure that available resources are utilised in the most effective way, however, the activation trigger for initiating CMP escalation remains qualitative; defined simply as demand exceeding available resources without numerical thresholds to support consistent or auditable decision-making **(see Key Finding 3)**.

Similarly, prioritisation within cancellation categories does not incorporate objective criteria or risk-based scoring, and certain journey cancellation triggers rely on subjective concepts such as having a "high level of confidence" that a journey can be accommodated. These gaps reduce clarity and introduce scope for inconsistent interpretation during periods of operational pressure**.**

Objective 2: Appropriate training is provided to staff responsible for processing transport requests.	**Reasonable**

The Trust has developed a structured training programme for call handlers, day controllers and journey planners, incorporating a blend of classroom-based induction, system-specific learning, supervised practice, and ongoing support.

The Cleric system is used to manage the patient journeys. New starters receive formal system training supported by detailed Cleric user guides, access to a training account with mock scenarios, shadowing of experienced colleagues, and a buddy arrangement to aid transition to live activity. Opportunities to further enhance this induction framework has been identified by the Trust. Managers review completion of training checklists and determine readiness for independent work, with additional support available following initial sign-off. Recent system interface changes have also prompted Trust-wide refresher training.

During our site visit to Vantage Point House (VPH), and acknowledging that practices may vary across sites, we noted that training records are not consistently captured or retained (see **Key Finding 1**). ESR reflects only mandatory ESR-based modules; module-specific checklists are not routinely uploaded to individual staff files, limiting the ability to evidence staff competence, training compliance, and alignment to CMP/SOP requirements.

The service has identified training gaps, and an updated training framework is currently in development to address areas such as managing difficult situations and mandatory vehicle familiarisation. However, no defined process has yet been established to systematically record and maintain these training activities (see **Key Finding 1**).

	Key Findings	Risk & Impact	Agreed Management Action
1	**Recording and Retention of Training Documentation** Training records are not consistently captured or stored across the service. ESR only reflects mandatory ESR-based modules. The module-specific training checklists (intended to evidence completion of system training, induction components and role-specific competencies) are not routinely uploaded to individual staff files. As a result, the Trust cannot reliably demonstrate that staff have completed the required training, nor provide assurance over competence, compliance with CMP/SOP requirements, or the consistency of training delivered across teams. Although we recognise the Trust is developing its training provision, such lacks a process to ensure training is consistently recorded and maintained.	Variability in decision-making across regions or staff could result in inequitable access to transport services.	**Agreed Action:** 1. A central training records framework will be developed defining mandatory modules (to consider ESR based), system-specific training, induction requirements and role-specific competencies; with recording of completed training on such mandated. 2. Periodic assurance checks will be undertaken to ensure that required training has been completed and records are maintained consistently. 3. Quarterly training compliance reports will form part of the Ambulance Care Quality Dashboard, which will be reported to Ambulance Care Formal and Quality Management Group. **Expected Evidence of Implementation:** 1. Approved training records framework and storage protocol. 2. Evidence of the training records being uploaded. 3. Inclusion of training compliance within the Ambulance Care Quality Dashboard.

Key Findings		Risk & Impact	Agreed Management Action
		Medium Priority	**Officer:** Karl Hughes: Head of Service, Ambulance Care Coordination
	Theme: Training & Development	Control Operation	**Target Implementation Date:** 31 March 2027

Objective 3: The Capacity Management Plan is implemented consistently, and decisions relating to transport requests are made in accordance with established procedures.	**Limited**

Journey booking

System-driven controls operate effectively at the booking stage for the telephone requests received. The Patient Needs Assessment (PNA) is embedded within the system and requires completion of all mandatory questions aligned to the eligibility criteria outlined in WHC 2007/005 before a booking can proceed. Walkthrough and call-monitoring testing, undertaken at the NEPTS contact centre during a site visit to VPH, confirmed that call handlers follow the scripted PNA and make eligibility decisions based solely on defined criteria.

Although the system-controls at the booking stage are functioning effectively, there is no mechanism to record or monitor patients deemed ineligible. This limits the Service's ability to monitor refusals, identify demand patterns, or detect inconsistencies in the interpretation of eligibility criteria (**see Key Finding 2**).

Journey planning and CMP activation

Decision-making during journey planning and activation of the CMP is significantly more variable. Although high-level prioritisation principles exist, (first renal and oncology patients, followed by seven mobility categories in order of priority i.e. stretcher patient, wheelchair user), journey planners can exercise considerable discretion when allocating resources, placing journeys on the unallocated list for 'on the day allocation', or selecting those for CMP cancellation (**see Key Finding 3**).

It is acknowledged that a certain degree of flexibility within the journey-planning process is both necessary and appropriate. The dynamic nature of demand, variations in patient mobility needs, journey distances, geographical challenges, and operational disruptions require planners to apply professional judgement to maximise the use of available resources. This human element, such as sequencing journeys based on proximity, anticipating late cancellations, or adapting to changes in staffing or vehicle availability, are an integral element to achieving operational efficiency. As such, some variation in practice is expected and reflects the practical reality of managing a complex, high-volume transport service within variable capacity constraints.

The service has developed a journey-planning checklist to aid planners in implementing the CMP consistently. However, based on practices observed at VPH, the tool is not routinely used in practice. In addition, the system does not provide functionality to record the rationale underpinning planning decisions, thereby limiting the service's ability to respond effectively should a patient dispute the decision or requests further review (**see Key Finding 4**).

Walkthrough testing confirmed that CMP cancellations are documented on the system using the standard code "CMP – No resource at planning." However, no additional narrative is captured to explain why certain journeys were allocated resources, and why others were cancelled, or how planners determined which cases should be placed on the unallocated list. The absence of documented reasoning for selecting lower-priority journeys for cancellation once capacity is exhausted limits transparency and auditability.

Monitoring consistency

Mechanisms for monitoring consistency of CMP application are inherently limited, particularly given that CMP activation occurs daily as demand exceeds capacity. Daily variation in demand patterns, mobility requirements, journey distances, individual planner discretion, and differences between health boards means that full consistency is neither expected nor feasible, and a degree of variation is appropriate within such a dynamic environment. Within these constraints, the service has implemented proportionate measures to monitor CMP usage, (see *objective 5* for further details). While these mechanisms cannot eliminate variability, they do offer meaningful visibility of CMP activity.

CMP activity data provided by the Trust further demonstrates an underlying degree of consistency across health boards. Despite the absence of documented rationale for individual decisions, lower-mobility categories (e.g., C3 – Own Wheelchair and C1– Walking Case) consistently account for the highest proportion of CMP cancellations.

Key Findings		Risk & Impact	Agreed Management Action
2	**Visibility of Eligibility Screening Outcomes and Incomplete Monitoring of Ineligible Patients** Despite effective front-end system controls for determining patient eligibility for transport, the service has no mechanism to record or monitor patients deemed ineligible following the PNA. Ineligible outcomes are not retained within the patient record, and no dataset exists to track refusals, reasons for refusal, or trends over time. This gap limits the ability of management to monitor the volume and nature of ineligible requests, assess whether eligibility criteria are being interpreted consistently, or identify potential training needs or quality issues. It also restricts visibility of demand that does not convert into bookings, reducing the Service's ability to understand unmet need.	Variability in decision-making across regions or staff could result in inequitable access to transport services.	**Agreed Action:** 1. A proposal will be developed that provides functionality within the Cleric system to record ineligible outcomes, the reasons for such, any advice provided to the patient and whether an appeal was made. Implementation will be subject to the identification of additional funding as required. 2. Monthly data analysis and reporting of the above dataset will be undertaken to identify, for example, trends or recurring reasons for ineligibility, potential inconsistencies in decision making, training needs for call handlers, levels of unmet need/demand not converting into bookings etc.
			Expected Evidence of Implementation: 1. Recording mechanisms embedded in the system and in active use. An approved proposal for the implementation of ineligible patient recording. 2. Implementation, subject to identification of funding, to deliver above proposal. 3. Defined database for monitoring ineligible outcomes; and actions / training improvements based on trends identified. 4. Reporting of output from database as part of the Ambulance Care Quality Dashboard reported to Ambulance Care Formal and Quality Management Group.
		Medium Priority	**Officer:** Karl Hughes: Head of Service, Ambulance Care Coordination
	Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** 31 March 2027
3	**CMP Triggers** While a Capacity Management Plan (CMP) exists, key triggers and prioritisation rules are not defined in measurable terms, relying instead on qualitative judgement; increasing the risk of	Inconsistent decision-making may undermine assurance over fair	**Agreed Action:** 1. Quantifiable CMP triggers will be developed; and these will replace/supplement qualitative descriptors to ensure consistent activation of capacity responses.

	Key Findings	Risk & Impact	Agreed Management Action
	inconsistent decision-making during periods of capacity pressure.	and robust journey prioritisation and cancellations.	**Expected Evidence of Implementation:** 1. Updated CMP with measurable triggers and prioritisation rules.
		Medium Priority	**Officer:** Karl Hughes: Head of Service, Ambulance Care Coordination
	Theme: Quality, Safety & Patient Experience	Control Operation	**Target Implementation Date:** 31 March 2027
4	**Audit Trail for Journey Planning and CMP Activation Decision** Supporting tools, such as the journey-planning checklist, are not routinely used and the system records only high-level cancellation codes without capturing the rationale behind planning decisions (e.g., why journeys are allocated, deferred or cancelled). insufficient documentation reduces transparency, limits auditability and increases the risk of inconsistent decision-making during periods of capacity pressure.	Undocumented decision-making may undermine assurance over fair and robust journey prioritisation and cancellations.	**Agreed Action:** 1. The routine use of supporting tools, including the journey-planning checklist, to ensure consistent planning practice will be mandated. 2. A proposal will be developed to enhance the recording on the Cleric system of cancellation and planning codes to capture the rationale behind decisions. Implementation will be subject to the identification of additional funding as required. 3. Inclusion within the NEPTS Quality Dashboard of period audits of CMP decision making.
			Expected Evidence of Implementation: 1. Communication of the mandatory use of the journey-planning checklist. 2. An approved proposal for the recording of Cleric system codes. 3. Updated Cleric system codes implemented and in use. Implementation, subject to identification of funding, to deliver above proposal. 4. CMP decision-making audit outcomes included within Quality Dashboard and reported to Ambulance Care Formal and Quality Management Group.
		High Priority	**Officer:** Karl Hughes: Head of Service, Ambulance Care Coordination
	Theme: Quality, Safety & Patient Experience	Control Operation	**Target Implementation Date:** 31 March 2027

Objective 4: Decisions are communicated effectively to patients and/or their representatives; with a defined process for patients to request a review of eligibility where transport requests have been declined.	**Reasonable**

Eligibility decisions

The service has established structured and consistent processes for communicating eligibility decisions to patients at the point of booking. Standardised scripts are used by call handlers when advising patients who do not meet the eligibility criteria outlined in the PNA, and observations of calls further demonstrated compliance with these scripts. Patients who disagree with an eligibility decision are informed of their right to request a review, and a defined review process is in place. Appeals are logged in the non-eligible review log and escalated to a supervisor, who re-assesses the call recording and, where appropriate, undertakes a re-review of the PNA using the extended criteria set out in the CMP SOP.

Whilst the eligibility review process is clearly communicated, the service does not monitor the number or nature of appeals submitted. There are no mechanisms in place to track appeal trends, analyse outcomes, or identify learning opportunities (**see Key Finding 5**).

CMP cancellations

CMP cancellations are applied as a last resort, at short notice, and only once all feasible options to accommodate the journey have been exhausted. As with eligibility decisions, cancellations under the CMP are communicated using standardised scripts and delivered consistently by Journey Coordination Centre staff. Patients are notified by telephone at least one working day before travel. Where patients do not answer, voicemail messages are left, and although patients are not explicitly offered a call-back, they may contact the main NEPTS contact centre to discuss the decision.

Despite the use of standard scripts, the communication to patients does not include a detailed explanation of the rationale behind CMP cancellations or articulate the application of prioritisation principles that underpin CMP decision-making (**see Key Finding 4**). In contrast to eligibility decisions, no formal review or appeal mechanism exists for patients whose journeys are cancelled under CMP. Given the time-critical nature of same-day and next-day planning, there is no practical window for a review to be undertaken without further delaying or disrupting journey allocation. Patients are instead signposted to the Trust's Putting Things Right process should they wish to raise concerns.

	Key Findings	Risk & Impact	Agreed Management Action
5	**Monitoring and Oversight of Eligibility Appeals** While the eligibility review process is clearly communicated to patients and consistently applied by call handlers, the service does not maintain any mechanism to monitor the number, nature, or outcomes of appeals submitted following an eligibility decision. There is no systematic tracking of how often eligibility decisions are challenged, whether particular themes or misunderstandings recur, or whether communication practices could be strengthened in response to patient feedback. Without this oversight, the service lacks visibility of trends, learning opportunities, and signs of process failure or inconsistency, limiting the Trust's ability to assess how effective its communication approach is.	Poor communication of decisions to patients and lack of clarity on review processes may increase dissatisfaction and complaints.	**Agreed Action:** 1. A SOP will be created for documenting and categorising appeals to ensure consistent recording by call handlers and reviewing officers. 2. A process will be developed to capture all appeals received. Details to be recorded will include reason for appeal, outcome (upheld/overturned). 3. Regular thematic analysis will be completed monthly and presented to the NEPTS weekly huddle and Quality Management Group to identify trends or recurring themes; areas where communication of guidance may need strengthening; indicators of inconsistencies in the eligibility assessment process. 4. Findings of the analysis will be reported routinely through the NEPTS Quality Dashboard and reported to Ambulance Care Formal and Quality Management Group.
			Expected Evidence of Implementation: 1. SOP approved and implemented. 2. Centralised appeal logging mechanism in use. 3. Thematic analysis report presented to the relevant NEPTS weekly huddle and Quality Management Group and documented improvements / actions arising from identified trends.
		Medium Priority	**Officer:** Karl Hughes: Head of Service, Ambulance Care Coordination
	Theme: Quality, Safety & Patient Experience	Control Operation	**Target Implementation Date:** 31 March 2027

Objective 5: Mechanisms are in place to capture and analyse performance information, such as journey cancellations, and to evaluate the impact of these on patients and their care, with reporting to appropriate forums both internally and externally.	**Reasonable**

The Trust has implemented a range of mechanisms to capture and analyse performance information relating to NEPTS activity, cancellations and CMP usage. At an operational level, the system records core datasets such as journey identifiers, patient mobility categories, booking and cancellation timestamps, and CMP-related triggers. CMP cancellations are consistently recorded using the standard code "CMP – No Resource at Planning," and the CMP trigger log provides meaningful insight into cancellation volumes, regional variation, and the mobility groups most affected. This information is further analysed through the dedicated Power BI Quality Dashboard, which is used routinely within weekly team meetings and the monthly NEPTS Formal Ambulance Care meetings to review trends, identify inconsistencies, and inform operational planning. In consideration of this data, the Trust may benefit from reviewing its booking methodology, with consideration given to basing bookings on capacity available at the time of the journey requirement rather than two days in advance.

While the system captures what has been cancelled and when, it does not record the decision-making rationale underpinning cancellations or journey-planning choices (refer to *objectives 3 & 4;* and **Key Finding 4**). This limits the completeness of the audit trail and constrains the ability to evaluate whether CMP has been applied consistently and in line with prioritisation principles. Similarly, although cancellation trends can be analysed accurately, the Trust currently lacks the capability to assess the downstream impact of cancellations on patient care.

NEPTS systems do not interface with health board clinical or appointment systems, meaning the service cannot determine whether a cancelled journey resulted in a missed or delayed appointment, or whether alternative arrangements were made, thereby limiting the Trust's understanding of patient impact (**see Key Finding 6**). There are currently no alternative mechanisms by which to gather or analyse such feedback. However, at the date of audit fieldwork, we note that a Civica survey was being developed to automatically contact patients affected by CMP cancellations and capture self-reported impacts. While this is a positive development, the functionality is not yet in place. This gap is reflected in wider patient experience data, where high satisfaction among transported patients contrasts with significant complaints relating to cancellations and unmet need.

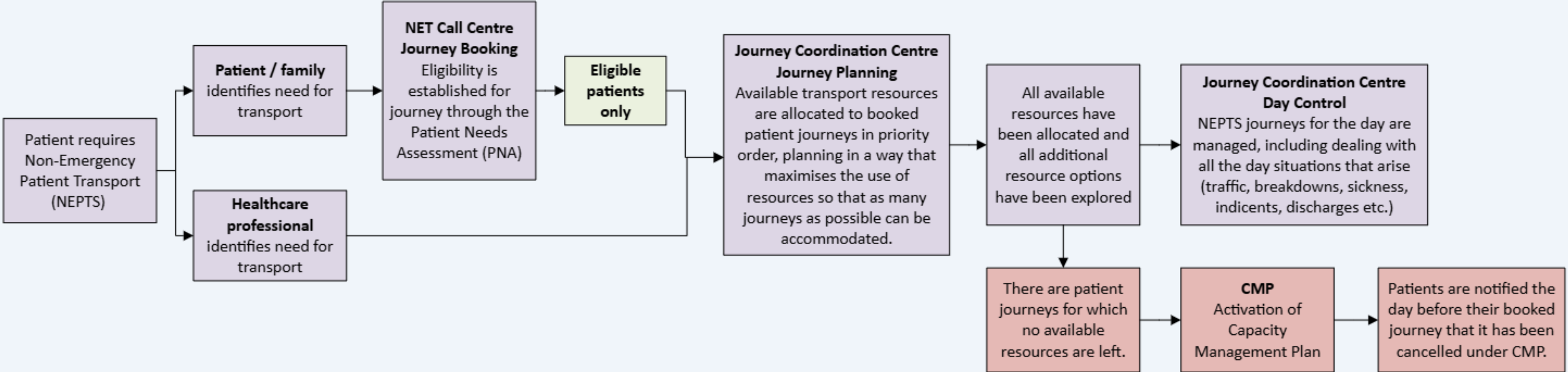
Oversight mechanisms are otherwise well embedded. The Monthly Integrated Quality and Performance Report (MIQPR) provides consistent reporting, including timeliness of renal and oncology journeys, NEPTS completed journeys, and CMP cancellations, to the Executive Leadership Team, the Quality, Patient Experience and Safety Committee (QUEST), the Finance and Performance Committee, and the Trust Board. Quarterly operational reports and bi-annual Patient Experience and Community Involvement reports further enhance triangulation. Externally, structured reporting to the Delivery Assurance Group (DAG), Commissioning Assurance Group (CAG) and the NHS Wales Joint Commissioning Committee (JCC) provides transparent system-level visibility of pressures, risks, activity and emerging issues.

	Key Findings	Risk & Impact	Agreed Management Action
6	**Ability to Assess the Impact of Cancellations on Patient Care** The Trust lacks the ability to assess the downstream impact of cancelled NEPTS journeys on patient care. NEPTS systems do not interface with Health Board clinical or appointment systems, so the service cannot confirm whether cancelled journeys led to missed or delayed appointments, whether alternative arrangements were made, or whether cancellations affected treatment or wellbeing. As a result, understanding of patient impact is limited to internal operational data and feedback from patients who received transport. A Civica survey is being developed to automatically contact patients whose journeys are cancelled under CMP and capture self-reported impacts; however, this mechanism is not yet implemented.	High cancellation rates or delays in transport could lead to missed appointments, delayed treatment, and adverse health outcomes.	**Agreed Action:** 1. The Civica patient impact survey will be explored (subject to Data Protection Impact Assessment) to gather patient feedback on journeys cancelled under CMP. If feasible, survey content will capture missed/delayed appointments, treatment impact, alternative arrangements made and any patient wellbeing issues. 2. We will introduce a process whereby the enhanced service hub will, as part of their routine operations, review any enhanced CMP cancellations (e.g. oncology, renal). 3. Subject to an effective survey, responses will be collated and analysed integrating findings into performance reporting to identify patterns, risks and high-impact cancellation types. 4. Quarterly reporting to Ambulance Care Formal and Quality Management Group providing patient impact insight to support service improvement and strategic planning.
			Expected Evidence of Implementation: 1. Civica impact survey implemented and functioning. 2. Enhanced Service Hub review process in place. 3. Interim manual process documented and in operation. 4. Defined analysis and reporting process approved. 5. Quarterly reporting to Ambulance Care Formal and Quality Management Group.
		Medium Priority	**Officer:** Karl Hughes: Head of Service, Ambulance Care Coordination
	Theme: Quality, Safety & Patient Experience	Control Operation	**Target Implementation Date:** 31 March 2027

Appendix A: Non-Emergency Patient Transport Services Process Map

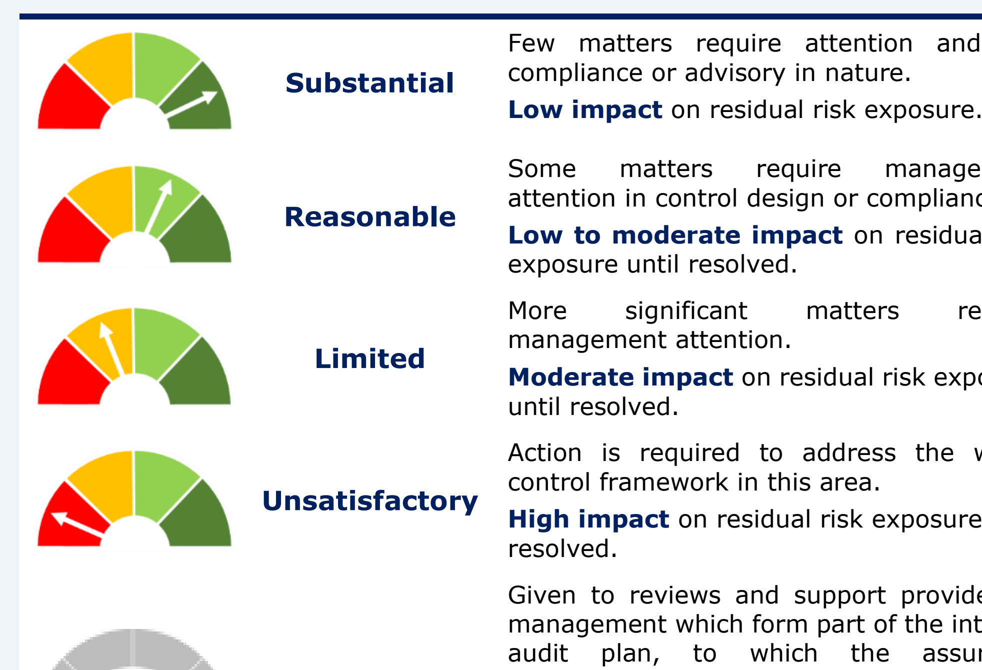
Patient Transport Booking Through to Capacity Management Plan Cancellation

The process map was developed through walkthrough testing undertaken at Vantage Point House during the course of audit fieldwork.



Appendix B: Assurance Opinion & Prioritisation of Findings

Assurance Opinion



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

Prioritisation of Findings

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

Disclaimer

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

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

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

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

Public Sector Internal Audit Standards

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

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

Job Evaluation

Final Internal Audit Report

2025/26

Welsh Ambulance Service University NHS Trust

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Review Reference	WAS-2526-18
Fieldwork	January 2026 - February 2026
Executive Sign Off	26 March 2026
Audit Committee	28 April 2026
Executive Lead	Carl Kneeshaw, Director of People
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

Executive Summary

Purpose

To assess how effectively the requirements of the NHS Job Evaluation Handbook are being applied by the Welsh Ambulance Services University NHS Trust (the Trust).

Overview

Job evaluation is the process of determining the relative value of a job compared to other roles within an organisation, with the aim of establishing a fair and rational pay structure. It is a key part of the pay system for NHS staff covered by the 'NHS Terms and Conditions of Service Handbook' (Agenda for Change). One of the aims of Agenda for Change is to enable NHS bodies to operate more flexibly by redefining and developing roles in partnership, supporting the ongoing modernisation of services for the benefit of patients.

The introduction of the NHS Job Evaluation Scheme ensures that all posts are assigned to appropriate pay bands through a structured job matching and evaluation process. This approach ensures fairness, consistency, and equality for all staff. The Trust is required to comply with the standards set out within the NHS Job Evaluation Handbook (the Handbook).

Alongside the NHS Handbook, separate guidance is in development at the Trust designed to help managers understand the job evaluation process and access additional resources, including reference to the expected target time for completion of the job evaluation process. When replacing vacant posts, managers need to consider whether the existing role remains appropriate or whether it can be redesigned to align with service improvement and evolving organisational needs.

An assessment of the Trust's job evaluation function was undertaken in January 2025 to identify the causes of backlogs during periods of heightened demand and to determine priorities for strengthening the function's capacity and resilience. The findings from this review informed recommendations to streamline the process and enable the function to meet future demand sustainably. An action plan was subsequently developed, outlining short and medium-term initiatives. A 14-day turnaround target was identified as a future goal for the completion of the job evaluation process (compared to the current, albeit not formally documented, 28-day requirement). However, we note that limited reporting has taken place on progress against these actions due to resourcing constraints.

The current structure aligns to the findings and resulting requirements of the assessment. At the time of audit fieldwork (January 2026), there were no resource gaps and no backlog of job evaluations.

We have concluded **reasonable** assurance for this review. The matters require management attention include:

1. Ratification of the Job Evaluation Standard Operating Procedure is required to provide clear operational guidance and ensure consistent application of the JE process
2. Delays in progressing job matching occur due to limited availability of trained panel participants (both staff-side and management), leading to panel cancellations and reduced resilience, affecting timeliness and potentially impacting the experience of staff awaiting outcomes.
3. Documentation and audit trail weaknesses persist, consistent with the findings of our previous Job Evaluation report (issued February 2021; limited assurance). Issues include incomplete or missing records of matching, re-evaluation and consistency checking activity, insufficient evidence of attendance and gaps in supporting documentation.
4. No recent or structured training has been delivered for job matchers, analysts, or consistency checkers, and no central record of practitioner training is maintained. Again, this is consistent with the findings of our previous review.
5. Conflicts of interest identified, with some individuals participating in both job matching and consistency checking panels for the same job description.
6. Monitoring and reporting against agreed JE improvement actions is insufficient, with no recent updates presented to the Executive Leadership Team.

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

Scope & Assurance Summary

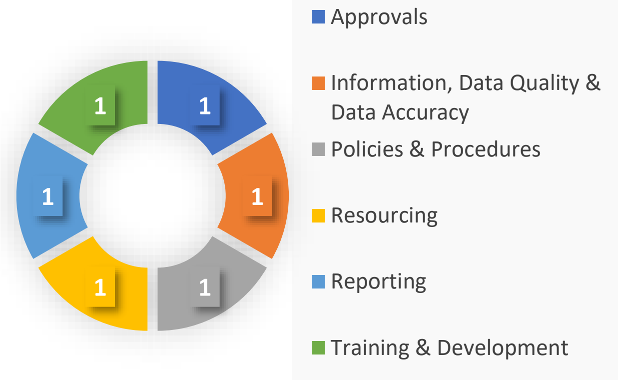
Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Objectives	Related Findings	Assurance
1	The Trust has appropriate policies and procedures in place, which clearly set out the job evaluation process, roles and responsibilities, and promote fairness, consistency and equality for all members of staff.	1	**Reasonable**
2	Arrangements for managing the evaluation of new posts, re-evaluations of changed posts and outcome review requests are compliant with policy.	1,2,3	**Reasonable**
3	Staff involved in job matching, analysis, evaluation, and outcome review requests have received suitable training and support.	2,4,5	**Limited**
4	Appropriate local consistency checking requirements are in place and meet the recommendations set out in the NHS Job Evaluation Handbook.	3,5	**Reasonable**
5	Periodic analysis reporting to an appropriate committee is taking place and is evident.	2,6	**Reasonable**

Management Actions

-	6
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

At a Glance: People and Culture KPIs

Table 1: Number of job descriptions in process/completed [1]

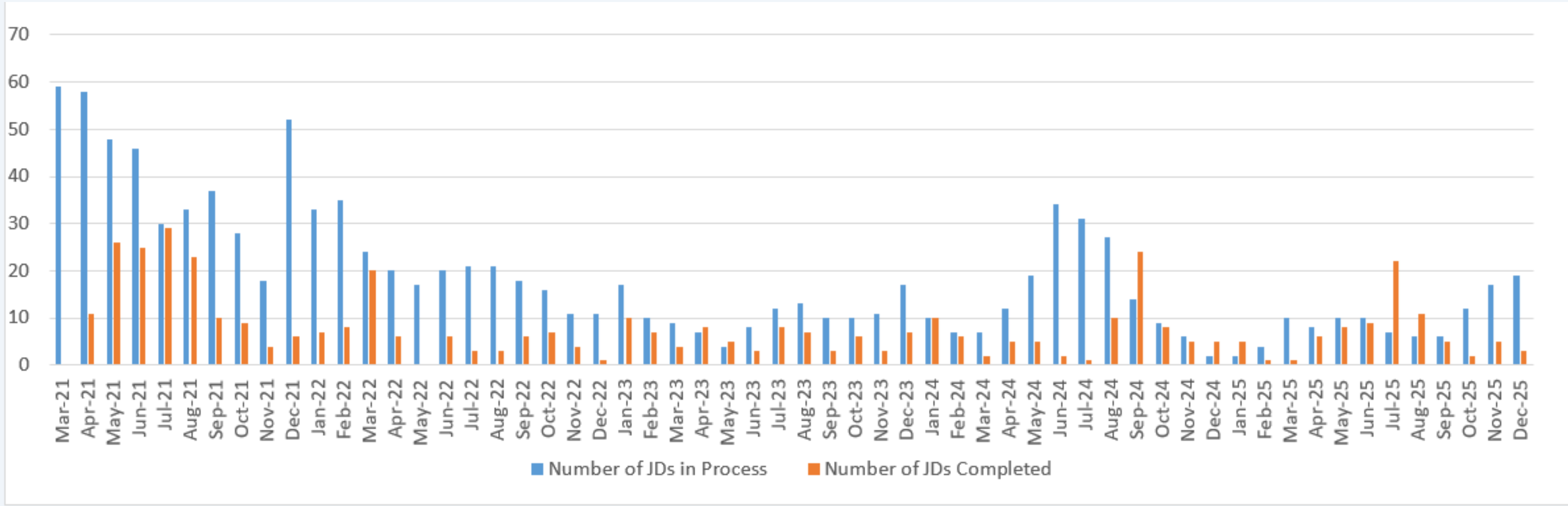
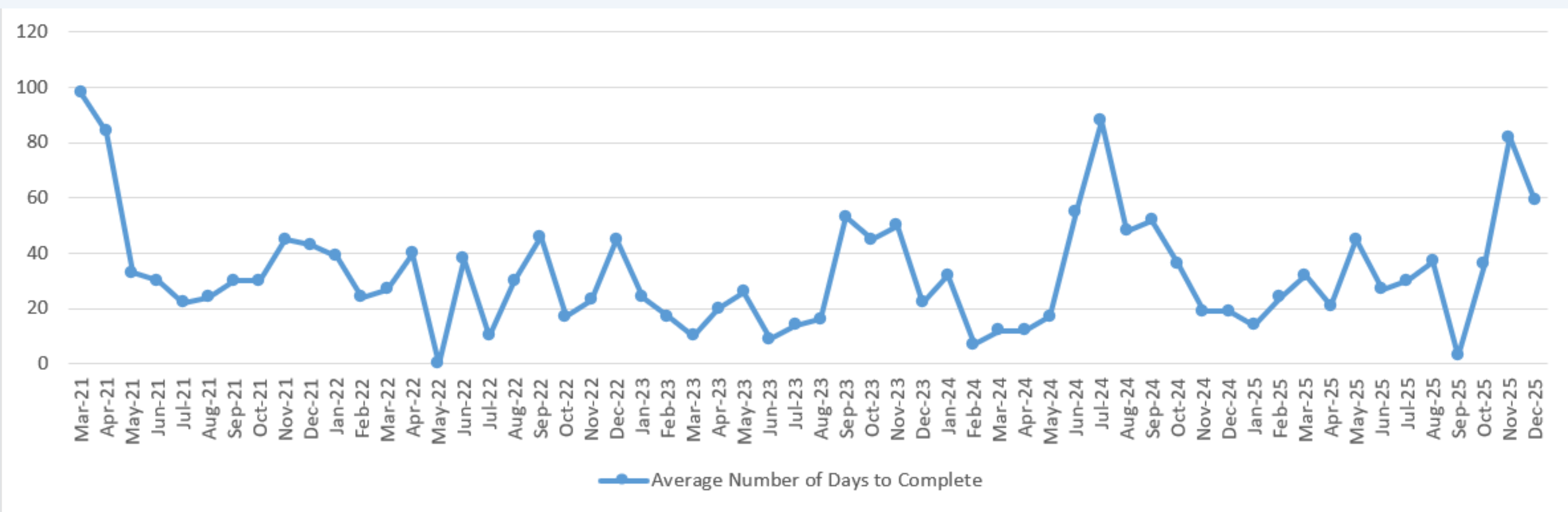


Table 2: Average number of days taken to complete the job evaluation process [1]



[1] *Metrics extracted from data presented to the People and Culture Committee (February 2026)*

Findings & Agreed Action Plan

Objective 1: The Trust has appropriate policies and procedures in place, which clearly set out the job evaluation process, roles and responsibilities, and promote fairness, consistency and equality for all members of staff.	**Reasonable**

Our previous Job Evaluation (JE) audit (report issued February 2021; limited assurance) concluded that the combination of the NHS Wales Job Evaluation Handbook (the Handbook) and national procedures provided a strong framework for the JE process to operate in. These documents remain available and in use across the Trust.

The dedicated JE page on Siren provides access to the Handbook, the comprehensive guide for all NHS organisations, (now in its eighth edition and last updated in January 2024), as well as links to national guidance such as '*Introductions to Job Evaluation and Writing Job Descriptions*' and '*Writing Successful Job Descriptions*'. The page also includes brief statements outlining what constitutes (1) new roles, (2) changed roles; and (3) re-evaluations, alongside links to the job description and personal specification proformas.

Recent completion of this same audit at other NHS Wales organisations noted the presence of locally developed Standard Operating Procedures (SOPs) that supplement the Handbook by setting out the detailed local processes. These were supported by manager toolkits and a locally produced JE Handbook. Such supporting materials are currently not in place at the Trust. We recognise that WAST is a different type of organisation to Health Boards and that direct comparisons should therefore be treated with caution. However, consideration of the approaches adopted elsewhere could still provide useful context and help inform any future enhancements to the Trust's processes.

At the time of audit fieldwork, we were advised that a SOP for JE had been developed, with the intention of publishing by April 2026 - circa 12 months later than originally planned. The delay reflects challenges relating to team capacity, competing priorities and changes in JE management within the team (see **Key Finding 1**). This work stems from an assessment of the JE function undertaken in January 2025 and reported to the Executive Leadership Team (ELT). The assessment stated '*This procedure will provide managers with clear, practical guidance on preparing and submitting job descriptions, ensuring a transparent and consistent process across the Trust. Additionally, JE administrative processes will be reviewed and aligned with the new procedure to streamline the receipt and progression of job descriptions*.'

	Key Findings	Risk & Impact	Agreed Management Action
1	**Delayed development of the Job Evaluation Standard Operating Procedure (SOP)** The Job Evaluation Standard Operating Procedure (SOP), whilst drafted (albeit circa one year behind the original implementation deadline) has yet to be approved.	Inconsistent processes, reduced managerial clarity, and inequitable job evaluation outcomes, undermining confidence in the fairness and reliability of the JE process.	**Agreed Action:** 1. Job Evaluation SOP to be presented to the P&C Business Meeting by 31 May 2026 2. SOP published by 30 June 2026
			Expected Evidence of Implementation: • Agenda evidence from P&C Business Meeting • Approved SOP published, evidence of intranet communication to the organisation.
		Medium Priority	**Officer:** Liz Rogers, Deputy Director of People

Key Findings		Risk & Impact	Agreed Management Action
	Theme: Policies & Procedures	Control Design	**Target Implementation Date:** (1) 31 May 2026; (2) 30 June 2026

Objective 2: Arrangements for managing the evaluation of new posts, re-evaluations of changed posts and outcome review requests are compliant with policy.	**Reasonable**

Job evaluation (also known as job matching) occurs when a job description is matched against an existing national profile. Where no suitable profile exists, a job analysis questionnaire is completed, and a JE panel evaluates the role on its merits. A separate re-evaluation route exists for postholders who believe they are working beyond their current job description. In such cases, the individual must evidence the differences between their substantive role and actual duties, with approval from the line manager and budget holder before submission. All JE activity is undertaken within the national Computer Aided Job Evaluation (CAJE) system, with documentation stored electronically.

JE panels are routinely scheduled, with up to six sessions per week depending on the availability of job matchers. Whilst not formally documented (see **Key Finding 1**), local expectations require the JE process to be completed within 28 working days. We note positively that the Trust currently has no backlog of JE panels. The Handbook states that matching panels must operate in partnership and should ideally include equal numbers of Trade Union and management practitioners, typically four members (two of each). Panels may proceed with three or expand to five to support new practitioners' development. The Trust currently has 23 active management practitioners and 15 active Trade Union practitioners trained to undertake JE duties.

Due to a smaller pool of Trade Union practitioners, we are advised that panel cancellations do occur. Of the 98 panels scheduled between 1 January 2025 and 23 January 2026, 23 were cancelled: 14 due to unavailability of panel members (not clarified by role), 5 where no job descriptions were available for evaluation; and four with no recorded reason (see **Key Finding 2**). Operational pressures also limit the ability of practitioners, particularly Trade Union practitioners, to participate, as JE activities are often accommodated using Time Off in Lieu (TOIL) rather than formal release time. This can restrict practitioner availability, contribute to cancellations, and pose resilience risks for the JE process (see **Key Finding 2**). However, as previously noted, there is currently no backlog.

We reviewed all JE submissions received between 1 January 2025 and the date of audit fieldwork (5 February 2026). Thirty-nine submissions were recorded, covering new posts, re-bandings, re-evaluation, and banding outcome review requests. A sample of ten JEs and five re-evaluations across a range of bands were examined in detail to assess compliance at each stage. While core job descriptions and technical documents were available in all cases, we identified several inconsistencies in documentation quality and completeness, mirroring issues reported in our previous JE audit (February 2021). Whilst key dates were confirmed following the audit fieldwork, supplemental documentation was not provided for all. It is anticipated that the implementation of the SOP will strengthen these areas (see **Key Finding 1**). Issues identified, where enhancement in documentation is required, included:

- **Timeliness**: 6/10 JEs and 3/5 re-evaluations exceeded the Trust's internal requirement to complete the process within 28 working days, but we recognise this is within the timescale of 12 weeks as per the national guidance. (see **Key Finding 2**).
- **Missing proformas**: 3/10 JE files lacked the required proforma. All re-evaluations included them (see **Key Finding 3**).
- **Missing national profiles**: While all JEs contained national profiles, 3/5 re-evaluations did not (see **Key Finding 3**).
- **Welsh translations**: Evidence of required Welsh translations (Welsh Language Standard 107A) was absent in 3/10 JEs and 3/5 re-evaluations *(*see **Key Finding 3)**. The JE Team advised that translation is the responsibility of Recruitment. While re-evaluations do not always require immediate translation, good practice would support translating approved job description for future use. As advised by the Trust, there is currently not the organisational capacity to translate posts going through JE.

- **Consistency checking**: Evidence confirming that consistency panels had taken place was missing in 3/10 JEs and 1/5 re-evaluations. Attendance records were unclear in 6/10 JEs and 3/5 re-evaluations, and whilst further evidence was provided to confirm panels had occurred in line with the Handbook, documentation remained insufficient (see **Key Finding 3**).

We also assessed whether JE and consistency panels were free from conflicts of interest and whether individuals were not participating in both panels for the same job. While panels were held in accordance with the Handbook, some individuals attended both the matching and consistency panels for the same post (refer to *objective 4*).

Once the JE process is complete, the responsibility for the issue / communication is that of the managers / budget holders for the specific area.

Key Findings		Risk & Impact	Agreed Management Action
2	**Panel Cancellations** Of the 98 JE panels scheduled over the past 12 months (Jan 2025 to Jan 2026) a total of 23 were cancelled. 14 due to practitioner availability, five as there were no roles to evaluate and four had no recorded reason. – . Current practice at the Trust is for Trade Union practitioners to utilise TOIL to participate in job evaluation panels, which we are advised could be a barrier to participation. Accordingly, there is a small pool of trained and approved individuals from which the Trust can select for panels and cancellations occur. The implications of this are that several JE and re-evaluation cases exceeded the Trust's internal 28-day timescale for completion (6/10 JEs and 3/5 re-evaluations sampled), reflecting the impact of a range of contributing factors (e.g., delays in receipt of required supporting information from management, panel cancellations and potentially affecting the experience of staff awaiting outcomes. We do, however, note that the 28-day timescale is within the national guidance timescale of 12 weeks.	Reduced practitioner availability may cause delays and inconsistent scheduling, weakening the reliability of the JE process.	**Agreed Action:** 1. Rationalise the current list of trained practitioners to identify people who need to be removed. 2. Deliver refresher training to those who require it. 3. If required, expand the pools of trained, accredited practitioners, both managers and TU partners, but recognising the potential restrictions as a response organisation and circa 90% of TU partners being in operational roles. 4. Update the expected timescale for completion from 28-days to 8 weeks. Monitoring and report JE timeliness on this revised timescale to ensure cancellations, delays and capacity issues are routinely identified and escalated where necessary. Reporting will be to the People & Culture Business meeting (volumes) and to the Executive Leadership Team (exception reporting) **Expected Evidence of Implementation:** • Revised list of practitioners • Training session dates for refresher training (if appropriate) • Evidence of recruitment of new practitioners, and associated training (if required) • Reporting on the JE and re-evaluation process completion timeline to *the People & Culture Business meeting (volumes); and to the Executive Leadership Team (exception reporting).*
		Medium Priority	**Officer:** Liz Rogers, Deputy Director of People
	Theme: Resourcing	Control Design	**Target Implementation Date:** (1) 30 June 2026; (2) 30 November 2026; (3) 31 March 2027; (4) 30 June 2027

<table>
<tr><th colspan="2">Key Findings</th><th>Risk & Impact</th><th>Agreed Management Action</th></tr>
<tr><td rowspan="3">3</td><td rowspan="2">Inconsistent Documentation and Incomplete Job Evaluation Records
Testing identified multiple documentation gaps, including missing proformas, absent national profiles, incomplete evidence of consistency checking, unclear attendance records.
Further, there was limited evidence of required Welsh translations (Welsh Language Standard 107A). These issues mirror those identified in the previous JE audit and indicate inconsistent adherence to documentation standards.</td><td>Missing documentation reduces transparency and consistency, increasing the risk of challenge and weakening confidence in JE outcomes.</td><td>Agreed Action:
1. Create checklist for JE team to use as an audit tool / aide memoire to ensure all relevant paperwork is in place.
2. Development of opportunities to digitise JE processes to support document management.

Expected Evidence of Implementation:
• Updated guidance; and confirmation of route of issue and to whom.</td></tr>
<tr><td>Medium Priority</td><td rowspan="2">Officer: Liz Rogers, Deputy Director of People
Target Implementation Date: 31 December 2026</td></tr>
<tr><td>Theme: Information, Data Quality & Data Accuracy</td><td>Control Operation</td></tr>
</table>

Objective 3: Staff involved in job matching, analysis, evaluation, and outcome review requests have received suitable training and support.	**Limited**

Job Matching / Consistency Checking Training

The Trust maintains a register of job matchers and consistency checkers, with individuals marked inactive if they withdraw from duties. As noted under *Objective 2*, there are currently 15 Trade Union practitioners actively involved in JE/matching (three of which are also involved in consistency checking), and 23 management-side practitioners (15 of which also undertake consistency checking). These figures are broadly comparable with those reported in our previous Job Evaluation audit (15 staff side: 37 management).

The limited number of practitioners results in frequent reliance on the same individuals and has contributed to panel cancellations and, in some cases, conflicts of interest where individuals participate in both matching and consistency panels for the same job description (see **Key Finding 5**). The JE Team recognises the need to recruit additional practitioners, particularly from Trade Union partners, but notes that operational pressures make staff release challenging (see **Key Finding 2**).

Although the team advised that they only utilise job matchers and consistency checkers who have undertaken the appropriate training, we found that there is no central training record for job matchers and consistency checkers, and no recent formal training has been delivered as those undertaking panels have done so for some time (see **Key Finding 4**). This is consistent with the position at the time of our previous audit (final report issued February 2021), where we recommended a review of trained staff to assess readiness for active participation and identify training needs. Although the JE team is reviewing its training programme for 2026, no sessions had been scheduled at the time of audit fieldwork.

For practitioners who have not participated in a panel for an extended period, there is currently no structured refresher training, with optional shadow opportunities being the only informal option.

We note that actions are being taken to improve support and communication for those involved in JE process, although these will take time to embed. These include:

- A Teams channel for the JE Team (in place since 2022); and
- A JE Network Channel for all JE practitioners, expected to go live by the end of April 2026.

Manager Awareness Training

At the time of audit, the Trust did not provide structured manager awareness training. Rather, managers have access to guidance available on the Trust's JE SharePoint site, alongside ad-hoc support from the JE Team as needed.

Benchmarking against other NHS Wales organisations identified the availability of more structured training provision for managers in several areas, including Manager Pathway sessions, Manager Awareness sessions, and Job Description Writing Workshops. However, we note that the Trust is a smaller organisation with a lower demand for training. Manager advice and training is delivered on an ad hoc, one to one basis as required by the organisation.

We acknowledge that the forthcoming SOP is expected to provide enhanced and more consistent guidance for managers at the Trust once approved and implemented.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Gaps in Training Provision and Support for JE Practitioners and Managers** There is no recent or structured training available for job matchers or consistency checkers, and no central record is maintained of practitioner training. Refresher training is also lacking for individuals who have not participated in panels for extended periods, with shadowing being the only informal option. These issues were identified in the previous Job Evaluation audit (February 2021), where similar concerns were raised regarding the need to review trained staff, assess readiness for active participation, and address training gaps.	Lack of structured training and support may lead to inconsistent JE practice, inaccuracies, delays and reduced confidence in JE outcomes.	**Agreed Action:** 1. Create and maintain a central register (including last panel involvement) which can be used to inform panel selection and identify practitioners requiring upskilling. 2. Contact inactive practitioners to establish intent and deliver refresher training for those who have not participated in panels within 18 months; and remove those who will no longer be participating from the updated list. 3. Deliver structured training for new practitioners covering job matching, panel procedures, documentation, consistency checking etc; ensuring the training content reflects current national JE guidance as required.
			Expected Evidence of Implementation: • Training materials, including refresher training, and plans for / evidence of delivery. • Register in place and up to date
		Medium Priority	**Officer:** Liz Rogers, Deputy Director of People **Target Implementation Date:** (1&2) 30 June 2026; (3) 30 November 2026
	Theme: Training & Development	Control Design	

Objective 4: Appropriate local consistency checking requirements are in place and meet the recommendations set out in the NHS Job Evaluation Handbook.	**Reasonable**

Similarly to the JE Panels, there is only a small pool of 'active' Trade Union practitioners (15) and management practitioners (3) involved in consistency checking at the Trust. As a result, the same individuals are often involved in both JE panels and consistency checking panels (see **Key Finding 5**).

Individuals who participated in the original JE panel for a job description should not take part in discussions at the consistency checking panel for the same job (noting that multiple job descriptions may be considered at each meeting). Best practice requires that they recuse themselves from the relevant discussion, that such recusals are formally recorded, as was noted when completing a similar audit at another NHS Wales organisation, and that any instance reported to Local Partnership Forum and / or accompanied by a declaration of interest.

Consistency checking panels are currently scheduled on a fortnightly basis (previously they were arranged on an ad hoc basis) and are always conducted via Microsoft Teams. The JE Team confirmed that there have been no significant delays in scheduling panels, and there is currently no reported backlog.

From our sample of ten JEs and five re-evaluations, we assessed compliance with national consistency checking requirements. As previously reported, a number of documentation gaps were identified highlighting the need to improve on the audit trail that is being maintained; and for such to be maintained in a consistent manner as per the requirements of the Handbook. Evidence confirming that consistency checking panels had been held was absent for 3 of the 10 JEs and 1 of the 5 re-evaluations. In addition, panel attendance was not clearly documented in 6 of the 10 JEs and 3 of the 5 re-evaluations. Although this missing information were subsequently provided, and we were satisfied that the panels had been conducted in line with the national Handbook, the audit trail retained on file remains insufficiently robust (see **Key Finding 3**).

A spreadsheet is maintained to record key information for each consistency panel; however, panel outcomes are not consistently completed, with many fields remaining blank. Whilst no issues have arisen to date, ensuring this information is completed in full would strengthen the robustness and clarity of the audit trail.

Key Findings		Risk & Impact	Agreed Management Action
5	**Limited Practitioner Capacity and Inconsistent Documentation Undermine Panel Independence and Assurance Over Consistency Checking** A shortage of trained JE practitioners continues to result in individuals serving on both matching and consistency-checking panels for the same role, with three such instances identified in our sample. The constrained practitioner pool also affects operational resilience and panel scheduling. Panel documentation remains inconsistent in parts, limiting the ability to demonstrate compliance clearly. In contrast, in another NHS Wales organisation reviewed as part of similar audit work, internal consistency checking forms were completed	Limited capacity and inconsistent documentation increase conflict of interest risks and weaken confidence in JE outcomes; limiting the Trust's ability to evidence compliance.	**Agreed Action:** Consistent with the actions outlined in key findings 2 and 4: 1. If required, expand the pools of trained, accredited practitioners, both managers and TU partners, but recognising the potential restrictions as a response organisation and circa 90% of TU partners being in operational roles. *2.* Deliver structured training for new practitioners covering job matching, panel procedures, documentation, consistency checking etc; ensuring the training content reflects current national JE guidance as required.

Key Findings	Risk & Impact	Agreed Management Action
after each panel and stored alongside the job documentation. Whilst not a national requirement, this represents good practice and provides a more reliable and complete audit trail.		**Expected Evidence of Implementation:** Consistent with the evidence outlined in key findings 2 and 4: • Evidence of recruitment of new practitioners and associated training (if required) • Training materials, including refresher training, and plans for / evidence of delivery.
	Medium Priority	**Officer:** Liz Rogers, Deputy Director of People **Target Implementation Date:** 31 December 2026 (1) 31 March 2027; (2) 30 November 2026
Theme: Approvals	Control Design	

Objective 5: Periodic analysis reporting to an appropriate committee is taking place and is evident.	**Reasonable**

Internal Reporting

The JE team regularly runs activity reports from CAJE to monitor workload, outcomes and any anomalies. Verbal updates are provided at weekly team meetings, and key performance indicators (KPIs) are shared at the monthly People & Culture business meeting.

Updates are provided to the Executive Leadership Team (ELT) on request. The most recent update (January 2025) included an assessment of the JE function, the causes of previous backlogs, and priorities for strengthening capacity and resilience. An accompanying action plan set out short and medium-term initiatives; however, at the time of audit fieldwork, all actions remained outstanding, and no progress update had been reported back to ELT due to resourcing pressures within the JE team (see **Key Finding 6**).

We acknowledge that national guidance does not set out specific reporting requirements or KPIs; however, such measures would enhance organisational oversight and facilitate benchmarking. Within the Trust, a high-level summary of JE activity is presented quarterly to the People and Culture Committee. Reported metrics include the number of job descriptions in progress, completed within the month, and the average time taken to complete them. At the February 2026 Committee meeting, 19 job descriptions were in progress, three had been completed, and the average completion time was 59 days (which exceeds the Trust's internal KPI of 28-days - see **Key Finding 2**)

External Reporting and Networks

Organisations within NHS Wales are required to comply with All-Wales JE policy and maintain internal governance and audit arrangements; however, there is no requirement to submit JE performance or activity data to Welsh Government or any UK-wide body.

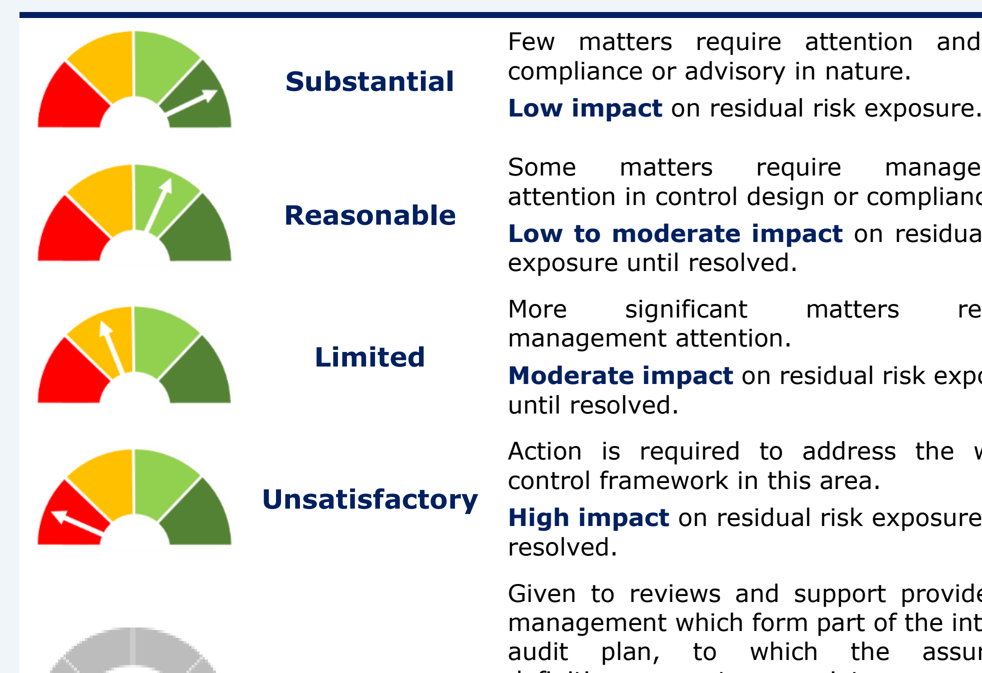
Although not formal reporting channels, there are a number of All Wales groups that support consistency, training and technical discussions. These include the Wales Monitoring Group, Wales Training Group, Wales Profile Group, Wales JE Technical Group, National Training Group, and the NHS Wales CAJE Review Meeting. In addition, an Association of Ambulance Chief Executives (AACE) group was established in 2025 to consider non-pay related JE points. While much of the content reflects NHS England priorities, the JE Lead attends these meetings where possible. Attendance has been restricted recently due to resourcing pressures within the JE team, though full establishment was reached in January 2026, and participation is anticipated to improve.

Recognising that the Trust operates differently to other UK Ambulance Services, and that their JE processes are not standardised, we acknowledge that the Trust does not benchmark its JE function or activities, nor does it maintain any formal links with other ambulance trusts for the comparison or shared learning.

	Key Findings	Risk & Impact	Agreed Management Action
6	**Weaknesses in Performance Reporting and Oversight Limit Assurance Over the JE Function** While periodic internal updates are provided, reporting on JE activity is not supported by clearly defined KPIs or agreed timeframes, limiting the ability to monitor performance and challenge delays. The audit confirmed that currently no evaluations were outstanding and there were no significant delays. Nevertheless, progress against the JE action plan has not been reported back to ELT due to resourcing pressures, reducing oversight of key improvement activity.	Without KPIs or oversight, JE delivery lacks transparency and assurance, increasing the risk of inefficiency, delays and unsound decisions.	**Agreed Action:** 1. Develop and approve a small set of KPIs covering timeliness, activity levels, cancellations, documentation quality and case backlog for routine monitoring at the People and Culture Business Meeting. *2.* Report to P&C Business Meeting on progress against plan ensuring sustained visibility of improvement activity.
			Expected Evidence of Implementation: • Relevant set of KPIs developed, for quarterly reporting to P&C Business meeting. • Progress reporting on the JE action plan to P&C Business Meeting.
		Medium Priority	**Officer:** Liz Rogers, Deputy Director of People **Target Implementation Date:** 30 November 2026
	Theme: Reporting	Control Operation	

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion



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

Prioritisation of Findings

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

Disclaimer

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

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

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

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

Public Sector Internal Audit Standards

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

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

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

Date issued: April 2026

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Introduction

This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at the Welsh Ambulance Services University NHS Trust (The Trust). We are presenting our 2026 Audit Plan to the committee in April 2026.

We also provide additional information on:

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

Accounts audit update

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

- **Executive Lead:** Executive Director of Finance and Corporate Resources
- **Focus of the work:** To provide an audit opinion on the Trust's 2025-26 Annual Report and Accounts.
- **Status:** The audit certification deadline for the 2025-26 accounts is 30 June 2026. We presented our outline Audit Plan at the meeting on 2 March 2026 and will present our detailed Audit Plan to the 28 April 2026 committee. This details the risks identified during the planning phase, along with the proposed timetable and audit fee.
- Audit fieldwork will commence on the 5 May 2026.
- **Expected committee date:** 23 June 2026

Performance audit update

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

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

Review of Non-Emergency Patient Transport Service

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

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

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

Other relevant publications

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

Additional Learning Needs: Do public bodies know if the system is working?	April 2026
Managing the Regional Integration Fund	March 2026
Checking the patients. Results from a pilot data matching exercise on GP patient lists	January 2026

Since the last committee update, Audit Wales has published its Annual Plan for 2026-27.

There are no relevant Audit Wales consultations currently underway.

Further information

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

Visit our website to find:

Our publications which cover our audit work at public bodies.

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

Data tools to help you better understand public spending trends.

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

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

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We welcome correspondence and telephone calls in Welsh and English.

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

Welsh Ambulance Services University NHS Trust - Audit Plan 2026

Date issued: April 2026

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Introduction

Adrian Crompton

Auditor General for Wales

I am pleased to share my 2026 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My Code of Audit Practice provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three lines of assurance model (page 21) sets out how we will ensure those standards of quality are met. Our latest annual audit quality report provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

My local performance audit work programme, as outlined in this Plan, sits alongside other national audit work that may include coverage of your organisation. Local performance audit work may also inform wider national reporting.

Should you have any questions about your audit my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

Our aims and ambitions

Our purpose

Assure people that public money is being managed well

Explain how that money is being spent

Inspire the public sector to improve

Our vision

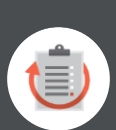
Fully exploiting our unique perspective, expertise and depth of insight

Strengthening our position as an authoritative, trusted and independent voice

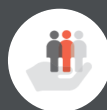
Increasing our visibility, influence, and relevance

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

Our areas of focus


A strategic, dynamic, and high-quality audit programme

A targeted and impactful approach to communications and influencing


A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our Annual Plan 2025-26 and Our Strategy 2022-27.

Financial audit work

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting standards and legal requirements, and the regularity of income and expenditure and the proper preparation of key elements of your Accountability and Performance Report. I lay them before the Senedd together with any report that I make on them.

I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

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

There have been no limitations imposed on me in planning the scope of this audit.

Financial statements materiality

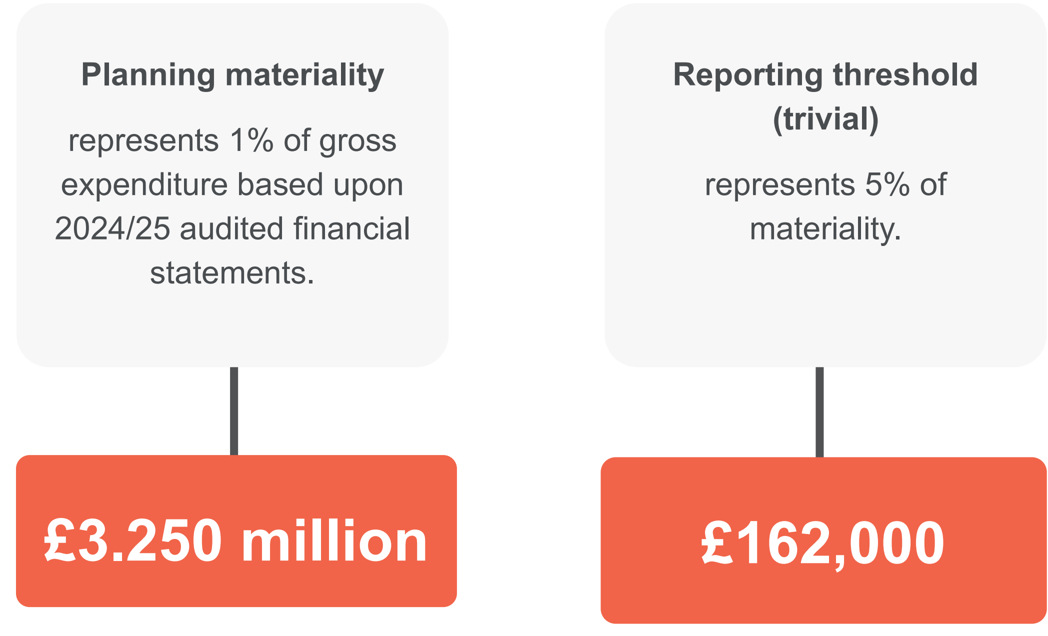
I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

I set planning and performance materiality to:

- Determine the level of misstatement that could cause the user of the accounts to be misled;
- Assist in the scoping of our audit approach and resultant audit tests;
- Determine sample sizes;
- Assess the effect of known and likely misstatements in the financial statements; and

- Report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.

The levels at which I judge such misstatements to be material is set out below.



There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

Remuneration report	Related party disclosures
The remuneration of senior officers and non-executive directors per the banding category £5,000	Related party disclosures with senior officers and non-executive directors £10,000

My audit team will assess materiality levels throughout the audit.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk.

Our planned response

My audit team will:

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and
- evaluate the rationale for any significant transactions outside the normal course of business.

Risk of fraud in expenditure recognition

There is a risk of material misstatement due to fraud in expenditure recognition and as such is treated as a significant risk [PN 10].

There is a risk that you will fail to meet your first financial duty to break even over a three-year period. The position at month 11 shows a year-to date surplus of £100,000 and a forecast year-end position of £nil. This, combined with the outturns for 2023-24 and 2024-25, predicts a three-year surplus of £155,000. Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure.

Your current financial pressures increase the risk that management judgements and estimates could be biased to achieve the agreed year end outturn and its financial duty.

There is a risk that cut off will not be correctly applied to expenditure incurred around the year end to ensure successful delivery of the year-end target.

Our planned response

The audit team will:

- substantively test all material areas of pay and non-pay expenditure;
- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review the basis of accruals for any estimation bias;
- review the year-end cut-off of expenditure; and
- test key year balances to ensure they were appropriate and complete.

Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

Remuneration report disclosures

There have been a few new permanent and interim appointments to senior officer and board member posts during 2025-26 which need to be captured in the remuneration report.

There is a risk that these are not appropriately disclosed in the remuneration report as remuneration paid to senior officers and board members continues to be of high interest and is material by nature.

Therefore, there is a risk that even low value errors in the disclosure could result a material misstatement.

Our planned response

My audit team will:

- understand the movements in the senior management team during 2025-26;
- ensure that remuneration disclosed is consistent with supporting evidence;

- ensure that amounts paid are consistent with those approved by the Board and are in accordance with Welsh Government pay rates; and
- ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.

Valuation of property assets

The value of property assets reflected in the balance sheet and notes to the accounts are material estimates.

Property assets are required to be held on a valuation basis which is dependent on the nature and use of the assets. This estimate is subject to a high degree of subjectivity, depending on the specialist and management assumptions, and changes in these can result in material changes to valuations.

Assets are required to be formally revalued every five years as a minimum, with indexation applied in interim years, but values may also change year on year, particularly where there are ongoing refurbishment projects resulting in subsequent expenditure being capitalised.

There is a risk that the carrying value of assets recognised in the accounts could be materially different to the current value of assets as at 31 March 2026.

Our planned response

My audit team will:

- review the indices used by management for reasonableness;
- evaluate the competence, capabilities and objectivity of the professional valuer who provide indices to management and undertake valuations as necessary;
- confirm that indexation has been appropriately applied and has been correctly reflected in the financial statements; and
- test the reconciliation between the financial ledger and the asset register.

Related party disclosures

The financial statements must disclose any related party relationships along with the transactions and balances between the Trust and the other body/party.

The Trust has many relationships that could be considered a related party. Many are well known for example, Welsh Government as funder.

However, where related party relationships arise via individual officer or member relationships, there is likely to be less transparency regarding these relationships. These transactions are of high interest and are considered to be material by their nature

There is a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.

Our planned response

My audit team will:

- review management's process for identifying related party relationships and associated transactions and balances;
- undertake procedures to confirm the completeness of related party relationships; and
- ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.

Provisions

The financial statements include provisions for legal obligations, particularly in relation to clinical negligence.

There is a significant degree of subjectivity and uncertainty in the measurement and valuation of these provisions.

This subjectivity and uncertainty increases the risk of material misstatement.

Our planned response

My audit team will:

- review management's estimation process for the valuation of provisions;

- consider the competence, capability and objectivity of the management experts who are prepare the estimates; and
- ensure that disclosures are in accordance with the FReM and Welsh Government's Manual for Accounts.

Capital expenditure

This is the first year in which the Capital Resource Limit (CRL) applies to the Trust, replacing the previous External Funding Limit. The Trust is required to utilise the capital funding allocated by the Welsh Government and there is significant investment in capital projects during the year. Capital expenditure up to month 11 was reported at £12.97 million, with a forecast of £32.79 million at year end, resulting in a substantial level of capital expenditure being required in March 2026.

There is a risk that capital classified as Assets Under Construction is materially mis-stated. There is an element of judgement needed when determining the amount of costs to be capitalised on each project and the valuation of these assets at the end of the year.

Our planned response

My audit team will:

- understand the reasons for the peak in capital expenditure predicted in month 12 and assess impact on audit approach;
- perform detailed testing on a sample of additions and capital accruals; and
- review and challenge whether any assets under construction require impairment.

Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

Exhibit 1: Financial statements audit timetable

January to April 2026	Planning meeting High level risk assessment procedures Fraud risk assessment Accounting estimates planning IT environment risk assessment and IT controls Detailed risk assessment procedures Develop testing strategy Indicative audit fee Outline Plan Draft Audit Plan
Fieldwork **May to June 2026**	Update risk assessment Audit of financial statements to include narrative report and annual governance statement Complete audit testing Evaluate audit findings Audit closure meeting
Reporting **June 2026**	Audit of Accounts Report Recommendations for improvement Present findings to those charged with governance Auditor General certification Submission of accounts to Welsh Government Laying of accounts with Senedd Cymru
Post-certification	Annual audit summary Post project learning

Performance audit work

Proper arrangements

As set out in the Code of Audit Practice, I must satisfy myself that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources ('value for money'), and conclude accordingly.

I do this by undertaking an appropriate programme of performance audit work each year. I base my work programme on an assessment of risks of the Trust and the wider NHS in Wales not having the proper arrangements in place, with the work typically focusing on the areas of greatest risk.

In designing the programme, my auditors must have considered corporate and service level arrangements, including:

Strategic planning

Financial planning

Performance and risk management

Workforce planning

Asset management

Collaborative working

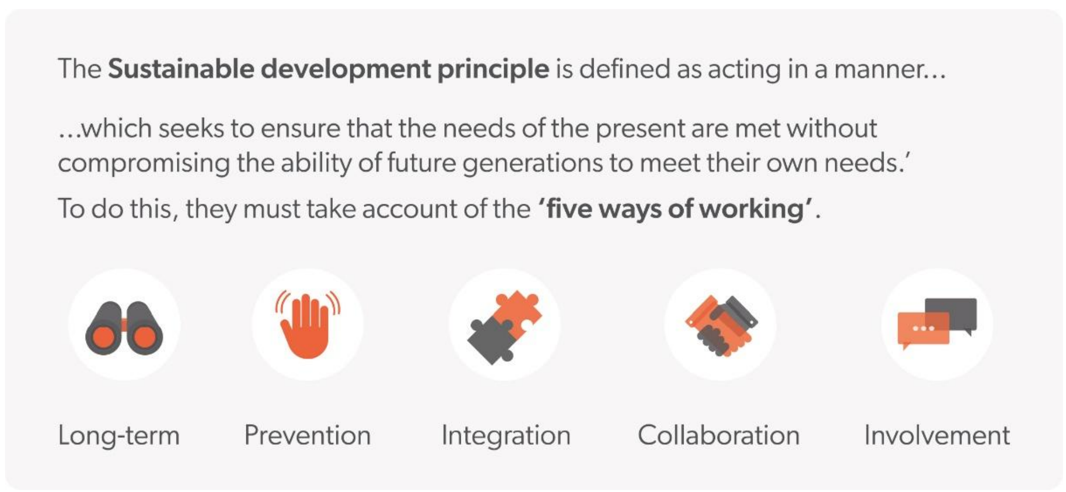
Overall governance.

My auditors will also have taken account of relevant work that is being undertaken or planned by other audit, regulatory and inspection bodies at the Trust.

I conduct my performance audit work using the ISSAI 3000 standard developed by the International Organisation of Supreme Audit Institutions (INTOSAI). INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

Well-being of future generations

Section 15 of the Well-being of Future Generations (Wales) Act 2015 (the Act) requires me to carry out examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle when setting well-being objectives and taking steps to meet those objectives.



I must carry out these examinations at each public body covered by the Act at least once during a specified period.

These could be stand-alone examinations as part of my performance audit programme. However, where relevant and appropriate to do so, my auditors will integrate the work required into other planned performance audit work for the Trust. My auditors will continue to engage closely with the Office of the Future Generations Commissioner for Wales to help coordinate our respective activities.

Planned performance audit work

I set out below details of my planned performance audit work.

Structured Assessment

Scope of the work

Structured assessment will continue to form a key part of the audit work my audit teams do at each NHS body.

My 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources.

This work will also review how the audited body tracks progress against previous audit recommendations. This helps the audit team check that improvements identified in earlier audits are being addressed. It also helps us measure the impact of our work more clearly.

My 2026 Structured Assessment work will also inform our thinking on whether we should undertake future work on hosted bodies' governance arrangements, particularly the Joint Commissioning Committee (JCC) and the NHS Wales Shared Services Partnership (NWSSP).

Indicative timescales

Fieldwork to commence between June and August 2026 and reporting by the end of December 2026.

Local project work – 111 service

Scope of the work

Where appropriate, my audit team will also undertake performance audit work that reflects issues specific to the Trust. The local performance audit work will focus on the governance, oversight and performance of the 111 service. This will also include a follow-up of the two recommendations made in our review of urgent and emergency care services at the Trust which reported in 2025.

Indicative timescales

Fieldwork to commence between June and August and reporting by October 2026.

Timing of Performance Audit Work

My team will work with officers in the Trust to arrange exact timescales for the individual projects and progress will be communicated regularly through our updates to the Audit, Risk and Assurance Committee. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2027.

Audit fee

In January 2026 we published our 2026-27 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 5.3%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

Based on those requirements, my estimated total audit fee for 2026 will be £216,942, an increase of 5.3% on my estimated 2025 fee.

Your estimated total audit fee: £216,942

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Executive Director of Finance and Corporate Resources. **Exhibit 2** sets out a further breakdown of your estimated audit fee.

I base my audit fee on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- The audit requirements of my individual performance audit projects are met by the audited body, or suitable alternative arrangements are put in place that satisfy the needs of my audit team.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 2: Breakdown of my estimated audit fee for 2026 (and 2025 for comparison)

Estimated fee for 2026 (£)[1]		Estimated fee for 2025 (£)	
Audit of financial statements[2]	Performance audit work[3]	Audit of financial statements	Performance audit work
£124,878	£92,064	£118,595	£87,423
Total fee: £216,942		**Total fee: £206,018**	

[1] The fees shown in this document are exclusive of VAT.

[2] Payable November 2025 to October 2026

Audit team

The main members of my team, together with their contact details, are summarised in **Exhibit 3**.

Exhibit 3: My local audit team

	Financial Audit	Performance Audit
Engagement Director	Tom Haslam tom.haslam@audit.wales	
Engagement Lead	Gareth Lucey gareth.lucey@audit.wales	Tom Haslam tom.haslam@audit.wales
Audit Manager	Yvonne Thomas yvonne.thomas@audit.wales	Darren Griffiths darren.griffiths@audit.wales
Audit lead	Sioned Owen sioned.owen@audit.wales	Fflur Jones fflur.jones@audit.wales

I can confirm that my team members are all independent of the Trust and your officers.

Staff secondment

An employee of Audit Wales is on secondment with you. In order to safeguard against any potential threats to auditor independence and objectivity, the following restrictions apply in line with the Financial Reporting Council's Revised Ethical Standard 2024:

- the secondee will not undertake any management responsibilities; and
- the secondment will be for a maximum of 12 months.

Audit quality

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

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

Our People

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

Arrangements for achieving audit quality Selection of right team

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

Independent assurance

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

Further Information

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

Our publications which cover our audit work at public bodies.

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

Data tools to help you better understand public spending trends

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

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

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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

Agenda Item No.	08

REPORT TITLE

Registers of Interests and Register of Gifts Hospitality and Sponsorship

MEETING

Name of meeting	Audit Risk and Assurance Committee
Date of meeting	28 April 2026
Public or Private	Public
If private - rationale	Choose item from below

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Lisa Trounce, Head of Compliance and Assurance

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The purpose of this paper is to present the Trust Board register of interests, Trust decision-makers register of interests, and the register of gifts, hospitality and sponsorship for the 2025/26 financial year, for review and receipt by the Audit, Risk and Assurance Committee. The registers have been presented as at the 31 March 2026.

2. It is a requirement of the Trust's Standing Orders and the committee's terms of reference that the Registers be received by the committee at least once annually.

3. All three registers were updated as at 31 March 2026. Board registers are presented to each board and committee meeting, further declarations are sought throughout the year and updates recorded as required regarding any new or ended interests. No issues arose during 2025-26 in relation to declarations of interest that required escalation to this committee.

4. The Trust decision-makers register of interests was finalised later in the year than was hoped in 2025/26. However, work will commence on the 2026-27 register in July 2026, with a view to completion by September 2026, avoiding the very busy quarters three and four.

5. Benchmarking the rate of WAST's gifts, hospitality and sponsorship declarations against other UK Ambulance Trusts indicated that, whilst still low, WAST's rate of declarations was not an outlier in terms of higher or lower rates of reporting.

6. The Corporate Governance Team is working closely with colleagues in the People and Culture Directorate and the Local Counter Fraud Specialist to identify any issues or risks that may be highlighted by the upcoming internal audit on secondary employment disclosure and associated control arrangements.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Audit, Risk and Assurance Committee is requested to:

1. Receive the Trust Board Register of Interests as at the 31 March 2026;

2. Receive the Trust Decision-Makers Register of Interests as at the 31 March 2026; and

3. Receive the Gifts, Hospitality and Sponsorship Register as at the 31 March 2026.

ADDITIONAL PAPER(S)

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

Annex 1 - Trust Board Register of Interests as at 31 March 2026
Annex 2 - Trust Decision Makers Register of Interests as at 31 March 2026; and
Annex 3 - Register of Gifts, Hospitality and Sponsorship 2025-2026

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
29/04/2026	Audit, Risk and Assurance Committee

SITUATION

1. The purpose of this paper is to present the Trust Board register of interests, decision-makers register of interests, and the register of gifts, hospitality and sponsorship as at 31 March 2026.

BACKGROUND

Declarations of Interest

2. The Trust's standing orders provision 8.1 requires all board members to declare any interests they may have which may affect or be perceived to affect the conduct of their role as a board member.

3. Standing order 8.1.3 states that the Chief Executive, through the Director of Corporate Governance/Board Secretary, will ensure that a register of interests is established and maintained as a formal record of interest declared by all board members.

4. Standing order 9.4.1 states that the Audit, Risk and Assurance Committee will review and report to the board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually. This report serves as the mechanism through which the register is received by this committee and the outcome of this review will be included in the AAA highlight report to the board.

5. Whilst the standing orders require a published register of interests for board members, they do not explicitly mandate a wider register for decision-makers. However, in the interests of good governance practice, this has been implemented within the Trust through local policy.

Declarations of Gifts, Hospitality and Sponsorship

6. Standing order 8.7 provides that the Director of Corporate Governance/Board Secretary is required "on behalf of the Chair, to maintain a register of gifts, hospitality and sponsorship to record those made to Board members. Executive Directors will adopt a similar mechanism in relation to Trust officers working within their directorates".

7. Standing order 8.7.5 provides that "The Board Secretary will arrange for a full report on all offers of gifts, hospitality and sponsorship recorded by the Trust to be submitted to the Audit Committee (or equivalent) at least annually". This report services as the mechanism through which the register is received by this committee.

ASSESSMENT

Declarations of Interest and Annual Eligibility Checks

8. The annual board member eligibility checks – which include the due diligence required on the individual declarations in addition to wider due diligence considerations – are in process. This activity informs the wider standards of business conduct framework in addition to the annual confirmation of declarations of interest and is reported to the Remuneration Committee.

9. The Trust Board register of interests as at the 31 March 2026 is presented here (Annex 1). This register is publicly available on the Trust website and is linked to the agenda for the board and all committees meetings.

10. Changes to the board register are made periodically through the year from proactive declarations from members, as well as the annual review of interests.

11. No issues that arose in 2025/26 that required escalation with respect to declarations of interest. Any conflicts that arose, whether actual or perceived, were managed in accordance with the standards of business conduct policy and the standing orders.

12. Trust decision making officers are defined as staff on band 8a and above, non-executive directors, and prescribed attendees for the board committees. In accordance with the policy, a publicly available register of interests for decisions makers is published annually. This register is shared with line managers to manage interests and any conflicts locally. The decision-makers register is here.

13. The Trust decision-makers register of interests was finalised later in the year than was hoped. However, work will commence on the 2026-27 register in July 2026, with a view to completion by September 2026, avoiding the very busy quarters three and four.

14. The standards of business conduct policy requires all staff to submit an annual declaration of interests, including where there are no relevant interests to declare. Robust arrangements are in place to capture declarations for board members and other key decision makers through the registers referenced above. Extending this level of assurance across the wider workforce via the Electronic Staff Record (ESR) system is not currently considered proportionate, taking into account the balance of resource required against the level of risk mitigated. It is anticipated that the implementation of the new ESR will support more flexible fields and improved reporting capability, enabling a more streamlined approach in future. In the interim, additional assurance will be provided through a planned internal audit in 2026/27 focusing on secondary employment disclosure and associated control

arrangements, which will identify any matters of concern relating to staff outside the primary decision making cohorts.

Declarations of Gifts, Hospitality and Sponsorship

15. There has been a series of organisational-wide communications since the beginning of 2024/25, with the latest directorate notice dated 07 November 2025, to aid understanding of the policy requirements, specifically in relation to gifts. These communications will be delivered on an ongoing basis throughout the year, particularly in the lead up to festive periods.

16. The offers of gifts, hospitality and sponsorship which have been declared during the 2025/26 financial year are detailed within the attached register (Annex 3). There were a total of nine declarations registered during 2025-26 financial year, compared to eight in 2024-25.

17. The Director of Corporate Governance/Board Secretary reviews and where necessary provides advice on declarations made.

18. In November 2025, a benchmarking exercise was undertaken comparing the rate of WAST's gifts, hospitality and sponsorship declarations to that of other UK Ambulance Trusts. The benchmarking exercise indicated that WAST's rate of declarations was not an outlier.

RECOMMENDATION

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

NEXT STEPS

20. Annual Board member eligibility checks which are underway to be concluded by the end of May 2026; and

21. Creation of a new register of gifts, hospitality and sponsorship to record declarations received during the 2026/27 financial year;

22. Re-issue of organisational-wide communications in April 2026 to aid understanding of the policy requirements

23. Collation of Trust Decision-Maker declarations of interest for 2026/27

24. Any updates to the declared interests of Board Members to be reported, recorded and published as an update as and when required throughout the year.

2025/26 REGISTER OF GIFTS, HOSPITALITY AND SPONSORSHIP DECLARATIONS (as of 31/03/2026)

REF	DATE OF DECLARATION	INDIVIDUAL	GIFT/DONATION/HOSPITALITY	VALUE
1	**04/07/2025**	**Ieuan Wyn Davies, Health Board Clinical Lead (Clinical)**	**Hospitality:** Travel and accommodation to attend EMEA LUCAS Symposium 2025 on 4th & 5th March 2025 in Lund, Sweden. **Purpose:** Linked to WAST Out of Hospital Cardiac Arrest (OOHCA) Strategy – pan Europe gathering of experts and guest speakers. Information gained was fed back to Operations / used to inform WAST plans to improve OOHCA / ROSC rates in Wales, aligned and contributed to the new Clinical Response Model categories (incl 'Purple' call code set).	Return flights from Manchester to Copenhagen. Plus one night hotel accommodation (half board basis). Flights 454.64EUR Accommodation cost not disclosed by the organiser (Stryker)
2	**08/07/2025**	**David Thomas, Health Board Clinical Lead (Clinical)**	**Hospitality:** Travel and accommodation to attend EMEA LUCAS Symposium 2025 on 4th & 5th March 2025 in Lund, Sweden.	Return Flights = 645EUR Accommodation costs not disclosed by the organiser (Stryker)

2025/26 REGISTER OF GIFTS, HOSPITALITY AND SPONSORSHIP DECLARATIONS (as of 31/03/2026)

REF	DATE OF DECLARATION	INDIVIDUAL	GIFT/DONATION/HOSPITALITY	VALUE
3	**22/09/2025**	**Keith Dorrington, Assistant Director Digital – CCIO (Digital)**	**Hospitality:** Return travel (flights) from Manchester to Rotterdam, hotel accommodation and entry fee to attend the European Resus Confed. 23rd – 25th October 2025. **Purpose:** At this event, the 2026 resuscitation guidelines will be released - these include the new use of AI. Attendance as part of the UK User Group of Corpuls Defibs (all other trusts who use the product will also be attending). During the event, the supplier (Ortus) will be holding this quarters User Group Meeting and introducing the new SDK, which will be used to upgrade the Corpus and link into ePCR to increase data capture.	£1,500
4	**23/09/2025**	**Stuart Roberts, Clinical Lead ePCR (Digital)**	**Hospitality:** Return travel (flights) from Manchester to Rotterdam, hotel accommodation and entry	£1,500

2025/26 REGISTER OF GIFTS, HOSPITALITY AND SPONSORSHIP DECLARATIONS (as of 31/03/2026)

REF	DATE OF DECLARATION	INDIVIDUAL	GIFT/DONATION/HOSPITALITY	VALUE
			fee to attend the European Resus Confed. 23rd – 25th October 2025. **Purpose:** At this event, the 2026 resuscitation guidelines will be released - these include the new use of AI. Attendance as part of the UK User Group of Corpuls Defibs (all other trusts who use the product will also be attending). During the event, the supplier (Ortus) will be holding this quarters User Group Meeting and introducing the new SDK, which will be used to upgrade the Corpus and link into ePCR to increase data capture.	
5	**Received on 21/10/2025** **(Signed by Manager on 19/11/2025)**	**Nic Anderson, Operations Manager – Volunteering and Community Resilience**	**Sponsorship:** Zoll sponsorship of WAST Volunteer Conference and Awards. The event took place on 27th September 2025 at Swansea Bay Campus, Swansea University. This sponsorship provides a clear	£2,000

2025/26 REGISTER OF GIFTS, HOSPITALITY AND SPONSORSHIP DECLARATIONS (as of 31/03/2026)

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			benefit to the Trust by supporting volunteer engagement, recognition and training through the national conference. The purpose of the event was to recognise and celebrate our volunteer service, share learning and strengthening engagement across the Trust and across volunteer roles and partner agencies. The sponsorship came from Zoll Medical UK Ltd. This was event sponsorship to support event delivery and awards. The benefit to sponsor was recognition as headline sponsor in the event materials and signage. They were also verbally acknowledged at the event and attended as exhibitors. This sponsorship does not compromise any Trust decision-making, is not linked to procurement or supply of goods or services, and the sponsor had no influence over event content, speaker selection or award	

2025/26 REGISTER OF GIFTS, HOSPITALITY AND SPONSORSHIP DECLARATIONS (as of 31/03/2026)

REF	DATE OF DECLARATION	INDIVIDUAL	GIFT/DONATION/HOSPITALITY	VALUE
			recipients. Executive Director of Operations, Lee Brooks, and finance were aware of the sponsorship prior to the event. The PO was raised by finance and arranged through the Business Support team directly to WAST.	
6	**17/11/2025**	**Liam Williams, Executive Director of Quality and Nursing**	**Hospitality:** 13.11.25 – Invited to and attended Quality Dinner: Spotlight on Cardiff and Vale University Health Board	Under £50.00
7	**18/11/2025**	**Hugh Bennett, Assistant Director of Commissioning & Performance**	**Hospitality:** Operational Research in Health (ORH) Conference, pre-evening, free food and drink	£45.00
8	**05/12/2025**	**Hugh Bennett, Assistant Director of Commissioning & Performance**	Meal in Chepstow funded by OMDA (providers of simulation software)	£30.00
9	**15/12/2025**	**Llanidloes Ambulance Station, c/o Claire Brittain (Locality Admin)**	League of Friends funds – used to purchase two armchairs.	£1,500

Total No. Of GSH Declarations received between 01/04/2025 - 31/03/2026 = 9

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

Agenda Item No.	09

REPORT TITLE

Self-assessment against the Corporate Governance Code for Central Government Departments 2027: 2026 Code review

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	28 April 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The Welsh Government Manual for Accounts requires that the board provide an assessment of its compliance with the Corporate Governance Code, with any explanations of departures, as part of the Governance Statement in the Annual Report. This self-assessment activity also informs the annual effectiveness review which is undertaken by the Trust Board.

2. The relevant Corporate Governance Code is The Corporate Governance Code for Central Government Departments (2017). NHS Wales organisations are not required to comply with all elements of the Code; however, the main principles of the Code stand as they are relevant to all public sector bodies.

3. The Code operates on a "comply or explain" basis, whereby any deviation from the Code's requirements must be explained as within the Governance Statement in the Accountability Report.

4. The 2025/26 self-assessment against the Code is set out at Annex 1, and the committee will note there are no elements currently showing an 'explain' rating. The Annex sets out the changes to the self-assessment against the 2024/25 self-assessment of the Code.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The ARAC is requested to:

1. Review the 2025/26 self-assessment against the Corporate Governance Code for Central Government Departments 2017, ahead of confirming compliance with the Code in the 2025/26 Accountability Report.

ADDITIONAL PAPER(S)

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

The ARAC is requested to receive the following:

1. Annex 1 – Corporate Governance Code 2017 Self-Assessment for 2025/26.

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

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

2025/26 SELF-ASSESSMENT AGAINST THE CORPORATE GOVERNANCE IN CENTRAL GOVERNMENT DEPARTMENTS – CODE OF PRACTICE 2017[1]

[HTTPS://WWW.GOV.UK/GOVERNMENT/PUBLICATIONS/CORPORATE-GOVERNANCE-CODE-FOR-CENTRAL-GOVERNMENT-DEPARTMENTS-2017](https://www.gov.uk/government/publications/corporate-governance-code-for-central-government-departments-2017)

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
1	Each organisation should have an effective board, which provides leadership for the business, helping it to operate in a business-like manner. The board should operate collectively, concentrating on advising on strategic and operational issues affecting the Trust's performance, as well as scrutinising and challenging departmental policies and performance, with a view to the long-term health and success of the Trust. (Code reference 2.1 and 2.2)	• The board meets in person bi-monthly, and committees meet quarterly, other than the Finance and Performance Committee which meets bi-monthly aligned to board meetings; and the Audit Risk and Assurance Committee which meets five times per annum. • The board routinely receives information on strategic activity, risk and performance as set agenda items. • The Integrated Medium-Term Plan (IMTP) is approved by the board and performance is scrutinised by the board and the Finance and Performance Committee. The IMTP is developed with engagement from staff and stakeholders. • Joint Executive Team (JET) meetings with Welsh Government colleagues were held quarterly until June 2025. • The Welsh Government Public Accountability Meeting took place on 05 March 2026 considering four key areas: delivering effective services, delivering in partnership, strengthening the organisation and looking to the future. • The board collaborates with partners and key stakeholders as described in the IMTP. • In early 2026 the board engaged the Good Governance Institute to undertake an external	Comply	• Board and committee minutes – demonstrate scrutiny and support. • Board and committee meeting schedule. • IMTP delivery reports to board and committees. • Audit Wales Structured Assessment 2025.

[1] The Code refers to central government nomenclature. This text has not been altered for NHS Wales organisations. NHS Wales organisations are not required to comply with all elements of the Code; however, the main principles of the Code stand as they are relevant to all public sector bodies.

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
		effectiveness review of the board and its committees to consider strategic alignment, robust assurance, timely and well-informed decision-making, and effective oversight of quality, performance and risk. It will include a review of the board committee framework. The outcomes of which will be reported to the board in May 2026.		
2	The Board does not decide policy or exercise the powers of the ministers. The department's policy is decided by ministers alone on advice from officials. The board advises on the operational implications and effectiveness of policy proposals. The Board will operate according to recognised precepts of good corporate governance in business: • Leadership – articulating a clear vision for the department and giving clarity about how policy activities contribute to achieving this vision, including setting risk appetite and managing risk • Effectiveness – bringing a wide range of relevant experience to bear, including through offering rigorous challenge and scrutinising performance • Accountability – promoting transparency through clear and fair reporting. • Sustainability – taking a long-term view about what the department is trying to achieve and what it is doing to get there. (Code reference 2.3)	• The Trust had its IMTP covering the period 2025-2028 approved by the Welsh Government and met its statutory duty to break even in 2025-26. • The board approved the IMTP for 2026-29 in March 2026 which is pending Welsh Government approval alongside the balanced financial plan in support of its delivery. This demonstrates to stakeholders that the organisation possesses the requisite level of maturity to plan and deliver our services with confidence over a three-year period. • The Trust's Model Standing Orders translate the statutory requirements set out in the National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I.1990/2024) (as amended) into day to day operating practice, and, together with the adoption of a Schedule of Reservation and Delegation and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the Trust. These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the Trust's Standards of Business Conduct Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.	Comply	• Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions. • IMTP. • Quality and Performance Management Framework. • Board minutes of meetings. • Committee annual reports. • Annual appraisals. • Engagement Framework Delivery Plan. • Audit Wales Structured Assessment 2025. • Decarbonisation action plan. • Chair/Vice Chair board reports. • A Llais representative present at board meetings • Representation at all Regional Partnership Boards.

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
		• The Trust refreshed the Quality and Performance Management Framework in 2025 which continues to promote transparency and accountability. • Committee effectiveness is reviewed annually, and Non-Executive and Executive Directors receive annual appraisals. • Sustainability is viewed through the lens of financial sustainability, value based healthcare, and the environmental and decarbonisation agenda, the latter being aligned to the Welsh Government decarbonisation action plan. The Trust refreshed its Engagement Framework Delivery Plan in 2025 to ensure our approach to discussing ideas with partners is robust. • From 1 April the organisation will align with the new NHS Wales operating and accountability framework.		
3	The Board should meet on at least a quarterly basis; however, best practice is that boards should meet more frequently. The Board advises on five main areas: • Strategic Clarity • Commercial Sense • Talented People • Results focus • Management information (Code reference 2.4 and 3.10)	• The board meets bi-monthly, and committees meet quarterly, other than the Finance and Performance Committee which meets bi-monthly aligned to board meetings; and the Audit, Risk and Assurance Committee which meets five times per year. All meetings were quorate in 2025/26. • The board routinely receives information on strategic activity, risk and performance, workforce planning matters as set agenda items. • Committees include these items in their terms of reference and appropriately scrutinise them at committee meetings, reporting to the board by way of highlight reports and minutes. • Highlight reports, known as 'AAA' reports (alert, advise, assure) are distributed to board members following a committee meeting, allowing for timely	Comply	• Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions. • Board and committee agenda, papers, minutes. • Board and committee meeting schedule. • Committee terms of reference. • Committee AAA reports. • Upload of AAA reports to website.

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
		escalations and are uploaded to the Trust's website within 14 days of the meeting. • The IMTP is approved and scrutinised by the board.		
4	The Board also supports the accounting officer in the discharge of obligations set out in *Managing Public Money* for the proper conduct of business and maintenance of ethical standards. (Code reference 2.7)	• The board approves the accountability report on an annual basis which includes the Statement by the Accountable Officer assuring the board on the Trust's system of internal control.	Comply	• Accountability Report.
5	Where Board members have concerns, which cannot be resolved, about the running of the department or a proposed action, they should ensure that their concerns are recorded in the minutes. (Code reference 2.12)	• Any concerns raised at board and committee meetings are formally recorded in the minutes. • The Chair and Director of Corporate Governance / Board Secretary are responsible for ensuring these matters are effectively managed, recorded and resolved where possible.	Comply	• Board and Committee minutes.
6	The Board should have a balance of skills and experience appropriate to fulfilling its responsibilities. The membership of the board should be balanced, diverse and manageable in size. (Code reference 3.1, 3.11, 3.12 and 3.13)	• The Trust's establishment order sets out the board composition, and the Trust abides by this composition. • The Standing Orders also captures the composition of the board. • Executive Director skill mix is considered prior to recruitment to align with the Trust's strategic objectives, and this is considered prior to new appointments. • A board skills matrix is maintained and applied with all new Non-Executive Director appointments. This was updated in 2025/26 as one of the recommendations from the effectiveness reviews. There will be a revised approach to the assessment of individual board member skills during 2026/27 overseen by the Audit, Risk and Assurance Committee. • Welsh Government Public Appointments Unit supports the process for recruitment of Non-	Comply	• Establishment Order and Standing Orders. • Membership matrix. • Board skills mix. • Audit Wales Structured Assessment 2025 noted the changes to Board membership have been managed well with an analysis of member skill mix implemented to support recruitment.

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
		Executive Directors with a standard role profile and person specification. • Non-Executive Director membership on board committees is reviewed annually to ensure there is mix and balance of experience across all meetings.		
7	The roles and responsibilities of all board members should be defined clearly in the department's board operating framework. (Code reference 3.2)	• These are included in the establishment order and standing orders, and Non-Executive Director appointment letters. • The board member induction programme sets out roles and responsibilities of all members of the board as well as attendees. • Director board members have individual job descriptions. • Responsibilities for individuals captured where appropriate in annual appraisals. • The Chair has annual objectives set and agreed by the Cabinet Secretary and cascades these to Non-Executive Directors as appropriate.	Comply	• Establishment order and standing orders. • Non-Executive Director appointment letters, and director job descriptions. • Objectives and appraisals (Non-Executive Director), and PADRs for directors.
8	The Finance Director should be professionally qualified. (Code reference 3.3)	• Executive Director of Finance and Corporate Resources is professionally qualified.	Comply	• Human Resources personnel file.
9	Independent Members will exercise their role through influence and advice, supporting as well as challenging the executive. (Code reference 3.5)	• Annual committee effectiveness reviews address the effectiveness of committee operating arrangements. • Welsh Government Non-Executive Director training captures effective challenge and scrutiny role on the Board. • Board visits SOP and heatmap captures members visits to staff.	Comply	• Committee annual reports. • Welsh Government induction training materials. • Annual Non-Executive Director objectives and appraisals. • Structured Assessment 2025. • Board Visits SOP and heatmap.
10	The board should agree and document in its board operating framework a *de minimis* threshold and mechanism for board advice on the operation and delivery of policy proposals.	• The Terms of Reference operating arrangements for the board committees articulate the remit and each cycle of business sets out the information that should be received.	Comply	• Terms of reference and operating arrangements. • Cycles of business. • Standing orders and scheme

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
	(Code reference 3.15)	• The scheme of reservation and delegation outline the information that should flow through to board and its committees as appropriate including policies.		of reservation and delegation.

FORMATTING ERROR – PLEASE KEEP SCROLLING DOWN

11	The Board Should ensure that arrangements are in place to enable it to discharge its responsibilities effectively, including: • formal procedures for the appointment of new board members, tenure and succession planning for both board members and senior officials • allowing sufficient time for the board to discharge its collective responsibilities effectively • induction on joining the board, supplemented by regular updates to keep board members' skills and knowledge up-to-date • timely provision of information in a form and of a quality that enables the board to discharge its duties effectively • a mechanism for learning from past successes and failures within the departmental family and relevant external organisations • a formal and rigorous annual evaluation of the board's performance and that of its committees, and of individual board members • a dedicated secretariat with appropriate skills and experience (Code reference 4.1)	• Non-Executive Director terms of office are monitored by the Chair and Director of Corporate Governance / Board Secretary to ensure succession planning is timely and managed in conjunction with the Public Appointments Unit in Welsh Government. • Standing orders and committee terms of reference provide for papers to be available to members in a timely manner, and a calendar incorporating these dates is maintained by the secretariat and communicated to members and report writers, together with the deadlines for such reports. Late papers are reported to the Audit, Risk and Assurance Committee as a non-compliance of standing orders. • The Trust has an induction programme for new board members. This programme consists of the following areas to ensure that a robust and supportive induction plan is in place for all new Board appointments: ○ Attendance at the mandatory Welsh Government induction training. ○ Provision of a detailed induction pack which includes information about the role of each board committee, their role as a Trustee and Non-Executive Director. ○ Core induction programme – planned within the first three months. This includes meeting with executives, partners, and site visits. ○ Completion of the Trust's welcome day induction for all new Trust staff. • The Chair undertakes annual appraisals of Non-Executive Directors and the CEO of Directors. • Annual committee effectiveness reviews address the effectiveness of committee operating arrangements. • In early 2026 the board engaged the Good Governance Institute to undertake an external board effectiveness review including committee structures, the outcomes of which will be reported to the board	Comply	• Membership matrix for board. • Skills matrix for board. • Standing Orders and committee and board paper deadline schedule. • Induction programme and associated documentation. • Appraisals. • Board development calendar and outcomes. • Committee terms of reference, agenda, minutes and cycles of business. • Audit Wales Structured Assessments.

		in May 2026. • The Trust has a schedule of Board Development Sessions throughout the year to discuss topical issues. • Committee terms of reference and reporting to Committees and the board embeds learning from events and post-implementation reviews. • Committees have cycles of business which are monitored at each meeting. • There is a dedicated secretariat for the board and its committees.		

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
12	The terms of reference for the nominations committee will include at least the following three central elements: • scrutinising systems for identifying and developing leadership and high potential • scrutinising plans for orderly succession of appointments to the board and of senior management, in order to maintain an appropriate balance of skills and experience • scrutinising incentives and rewards for executive board members and senior officials, and advising on the extent to which these arrangements are effective at improving performance (Code reference 4.5)	• The terms of reference and operating arrangements for the Trust's Remuneration Committee are based on the model standing orders and the scheme of reservation and delegation as approved by the Welsh Government. • Scrutinising systems for identifying and developing leadership and high potential is within the remit of the People and Culture Committee which reports to the board. • The Remuneration Committee approves the appointment of all directors, including those with voting rights. Non-Executive Director appointments are managed by the Welsh Government Public Appointments Unit, with members of the Remuneration Committee and board taking part in stakeholder panels. Appointments of Non-Executive Directors are made by Welsh Government. • Scrutiny of rewards and incentives, as well as performance of executive board members are included in the terms of reference of the Remuneration Committee.	Comply	• Remuneration Committee terms of reference and minutes. • Standing Orders and Scheme of Reservation. • People and Culture Committee terms of reference. • Welsh Government Non-Executive Director appointment process.
13	The attendance record of individual board members should be disclosed in the governance statement and cover meetings of the board and its committees held in the period to which the resource accounts relate. (Code reference 4.6)	• Board members attendance record for Trust Board is captured in the accountability report on annual basis and in each committee AAA report.	Comply	• Accountability Report. • Committee AAA reports.
14	Where necessary, board members should seek clarification or amplification on board issues or board papers through the board secretary. The board secretary will consider how officials can best support the work of board members; this may	• The role of the Director of Corporate Governance / Board Secretary is to act as principal advisor to the board and the organisation as a whole on all aspects of governance and ensure that it meets the standards of good governance set for the NHS in Wales. The Director of Corporate Governance /	Comply	• Director of Corporate Governance / Board Secretary job description. • Standing orders. • WAST writing guidance.

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
	include providing board members with direct access to officials where appropriate. (Code reference 4.10)	Board Secretary attends each board and committee meeting to ensure this support is in place. • Tools were put in place in 2025 by the corporate governance team to support report writers and ensure clarity of purpose of papers.		

15	An effective board secretary is essential for an effective board. Under the direction of the permanent secretary, the board secretary's responsibilities should include:
	• developing and agreeing the agenda for board meetings with the chair and lead non-executive board member, ensuring all relevant items are brought to the board's attention
	• ensuring good information flows within the board and its committees and between senior management and non-executive board members, including:
	• challenging and ensuring the quality of board papers and board information
	• ensuring board papers are received by board members according to a timetable agreed by the board
	• providing advice and support on governance matters and helping to implement improvements in the governance structure and arrangements
	• ensuring the board follows due process
	• providing assurance to the board that the department:
	  • complies with government policy, as set out in the code
	  • adheres to the code's principles and supporting provisions on a comply or
		• The Director of Corporate Governance / Board Secretary undertakes these roles for the Trust
		• The Director of Corporate Governance / Board Secretary meets with the Chair and executive lead of each committee to develop the agenda for the upcoming meeting, ensuring that it is driven by the principal risks for that committee.
		• The Director of Corporate Governance / Board Secretary drafts the AAA report for the review of the committee Chair and executive lead following each meeting and ensures any actions for other committees are transferred to their work programme appropriately.
		• The Director of Corporate Governance / Board Secretary attends each Committee meeting.
			Comply	• Director of Corporate Governance / Board Secretary job description.
				• Standing Orders.
				• Committee terms of reference.

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
	explain basis (which should form part of the report accompanying the resource accounts) • acting as the focal point for interaction between non-executive board members and the department, including arranging detailed briefing for non-executive board members and meetings between non-executive board members and officials, as requested or appropriate • recording board decisions accurately and ensuring action points are followed up • arranging induction and professional development of board members (including ministers) (Code reference 4.11)			
16	Evaluations of the performance of individual board members should show whether each continues to contribute effectively and corporately and demonstrates commitment to the role (including commitment of time for board and committee meetings and other duties). (Code reference 4.14)	• Individual appraisals are conducted for Non-Executive Directors by the Chair, and directors by the Chief Executive. • Committee effectiveness surveys indicate performance elements for the Chair. • The Director of Corporate Governance / Board Secretary meets annually with the Chair to review committee attendance and membership. • Attendance record reported in Accountability Report and committee AAA highlight reports.	Comply	• Committee annual reports. • Committee AAA highlight reports. • Accountability Report. • Appraisal documentation and process.

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
17	All potential conflicts of interest for non-executive board members should be considered on a case by case basis. Where necessary, measures should be put in place to manage or resolve potential conflicts. The board should agree and document an appropriate system to record and manage conflicts and potential conflicts of interest of board members. The board should publish, in its governance statement, all relevant interests of individual board members and how any identified conflicts, and potential conflicts, of interest of board members have been managed. (Code reference 4.15)	• The Trust has an agreed process in place for managing declarations of interest. • All board members are asked to formally declare on an annual basis and are advised of their responsibility to notify of any changes in year. • Declarations of interest are captured on a register which is available on the Trust website and is linked in the agenda of each board and committee meeting. • Declarations of Interest are captured at the start of each meeting. • The Standards of Business Conduct Policy and the standing orders detail the responsibility to declare interests.	Comply	• Standards of Business Conduct Policy. • Standing Orders. • Declarations of Interest Register and Accountability Report. • Agenda and minutes of each board and committee meeting.
18	The board should ensure that there are effective arrangements for governance, risk management and internal control for the Trust. Advice about and scrutiny of key risks is a matter for the board, not a committee. The board should be supported by: • an audit and risk assurance committee, chaired by a suitably experienced non-executive board member • an internal audit service operating to *Public Sector Internal Audit Standards*1 • sponsor teams of the department's key ALBs (Code reference 5.1 and 5.8)	• The Audit, Risk and Assurance Committee is chaired by a Non-Executive Director. • NWSSP Internal Audit Services are appointed as the Trust Internal Auditors. • The board receives the key risks at each meeting, as does the Audit, Risk and Assurance Committee and all other relevant committees.	Comply	• Terms of reference and operating arrangements for the Trust's Audit, Risk and Assurance Committee. • Accountability Report. • Board and Audit, Risk and Assurance Committee minutes. • Internal Audit Annual Plan 2025/26.

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
19	The board should take the lead on, and oversee the preparation of, the department's governance statement for publication with its resource accounts each year. The annual governance statement (which includes areas formerly covered by the statement on internal control) is published with the resource accounts each year. In preparing it, the board should assess the risks facing the Trust and ensure that the department's risk management and internal control systems are effective. The audit and risk assurance committee should normally lead this assessment for the board (Code reference 5.2 and 5.13)	• The annual governance statement is included within the accountability report, which is received by the Audit, Risk and Assurance Committee to endorse with approval by the Trust Board each year. • The system of internal control, including risk management, is set out in the governance statement.	Comply	• Accountability report. • Board and committee minutes. • Annual report timetable.
20	The board's regular agenda should include scrutinising and advising on risk management (Code reference 5.3 and 5.10)	• The Board Assurance Framework has been a standing agenda item for scrutiny and assurance on the Trust Board Agenda describing the Trust's principal risks. The report on assurance on avoidable harm, received at every board meeting, includes detail of the Trust's highest rated patient safety risks. • A refreshed strategic Board Assurance Framework is in development which will increasingly shape how harm-related risks and quality indicators are reported to the board. • The Trust's principal risks at reviewed in detail at each committee meeting, with assurance provided to the board through committee Chairs and the Alert, Assure, Advise (AAA) mechanism. • The Audit, Risk and Assurance Committee provide assurance to the board that there is a robust Risk Management Framework in place.	Comply	• Trust board agenda and minutes. • Audit, Risk and Assurance Committee agenda and minutes and terms of reference. • Audit Wales Structured Assessment 2025 • Internal Audit Risk Management Review 2025/26.

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
21	The key responsibilities of non-executive board members include forming an audit and risk assurance committee. The board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members. An audit and risk assurance committee should not have any executive responsibilities or be charged with making or endorsing any decisions. It should take care to maintain its independence. The audit and risk assurance committee should be established and function in accordance with the *Audit and risk assurance committee handbook.* The board should ensure that there is adequate support for the audit and risk assurance committee, including a secretariat function. The terms of reference of the audit and risk assurance committee, including its role and the authority delegated to it by the board, should be made available publicly. The department should report annually on the work of the committee in discharging those responsibilities Boards should ensure the scrutiny of governance arrangements, whether at the board or at one of its subcommittees (such as the audit and risk assurance committee or a nominations committee). This will include advising on, and scrutinising the department's implementation of, corporate governance policy.	• The standing orders are explicit that the Trust as a minimum must establish committees that cover certain aspects, one of which is Audit. • The Audit, Risk and Assurance Committee is established. • The terms of reference and operating arrangements in respect of the Audit, Risk and Assurance Committee are clear in relation to its authority and delegated responsibilities and is supported by a cycle of business. • A full secretariat function is in place supporting the Audit, Risk and Assurance Committee. • The Audit, Risk and Assurance Committee terms of reference are published as an appendix to the standing orders on the Trust's website. • The Board Assurance Framework is scrutinised by the board and Audit, Risk and Assurance Committee at each meeting. • The Audit, Risk and Assurance Committee reports to the board by way of a AAA report after each meeting. • The committee reviews its effectiveness annually against the NAO toolkit.	Comply	• Standing Orders. • Terms of reference and cycle of business for the Audit, Risk and Assurance Committee • Board Assurance Framework reported to Board and Audit, Risk and Assurance Committee throughout 2025/26 • Board and Audit, Risk and Assurance Committee minutes • Audit, Risk and Assurance Committee AAA reports for 2025/26. • Annual quality and governance review.

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
	(Code reference 5.4 and 5.9, 5.11, 5.12 and 5.14 and 5.15)			
22	The head of internal audit (HIA) should periodically be invited to attend board meetings, where key issues are discussed relating to governance, risk management processes or controls across the department and its ALBs (Code reference 5.5)	• The role of the Head of Internal Audit (HIA) is clearly set out in the Trust standing orders. • Internal Audit colleagues attend all Audit, Risk and Assurance Committee meetings which report to Board. • The HIA is invited to all board and committee meetings of the Trust and regularly attends. • The Chair of the Audit, Risk and Assurance Committee attends regular meetings with the HIA. •	Comply	• Standing orders. • Terms of reference for the Audit, Risk and Assurance Committee.
23	The board should assure itself of the effectiveness of the Trust's risk management system and procedures and its internal controls. The board should give a clear steer on the desired risk appetite for the department and ensure that: • there is a proper framework of prudent and effective controls, so that risks can be assessed, managed and taken prudently • there is clear accountability for managing risks • Departmental officials are equipped with the relevant skills and guidance to perform their assigned roles effectively and efficiently. The board should also ensure that the department's ALBs have appropriate and effective risk management processes through the department's sponsor teams	• The board approves the risk management policy. • Implementation of the risk management framework is overseen the Director of Corporate Governance / Board Secretary. • Principal risks drive the agenda of the board and committees and are reviewed at each meeting, ensuring robust oversight and informed decision-making. This approach enables early identification, assessment, and effective management of risks, supporting the delivery of safe, high-quality services and compliance with statutory and financial duties. • In November 2025 the board approved risk appetite statements defining the level of risk the Trust is willing to take or accept in pursuit of its strategic objectives. These will be reviewed annually or sooner if required by material change. • The Audit, Risk and Assurance Committee will oversee the next steps in guiding decision making across the Trust.	Comply	• Board and Audit, Risk and Assurance Committee agenda and minutes. • IMTP. • Risk Management Policy. • Internal Audit for Risk Management and Assurance. • Structured Assessment 2025. • Risk appetite statements.

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	Comply or Explain	Supporting documentation
	Advising on key risks is a role for the board. The audit and risk assurance committee should support the board in this role. (Code reference 5.6, 5.7 and 5.10)	• Members of the board and Audit, Risk and Assurance Committee discuss, challenge and support the discussions on key risks at every meeting, particularly those rated 20 and above. • The Internal Audit for Risk Management and Assurance in Quarter 4 of 2025-6 provided for 'reasonable assurance'.		

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

Agenda Item No.	10

REPORT TITLE

Review of Governance Practice Notes

MEETING

Name of meeting	Audit, Risk and Assurance Committee
Date of meeting	28 April 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The Trust's governance practice notes have undergone a cyclical review and are presented for approval. The changes made are minor and reflect the current practices applied within the Corporate Governance Directorate and changes to role titles. The practice notes are presented to the Audit, Risk and Assurance Committee (ARAC) for approval.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The ARAC is requested to:

1. Review and approve the edited governance practice notes 001, 002 and 003.

ADDITIONAL PAPER(S)

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

The ARAC is requested to receive the following:

1. Annex 1: GPN 001 for the application/use of the Trust Seal.
2. Annex 2: GPN 002 for the treatment of business for private board/committee meetings.
3. Annex 3: GPN 003 for the treatment of business via Chair's Action.

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]

☐ SO1: Providing the right care or advice, in the right place, every time	☐ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☐ SO4: Developing services in collaboration
☐ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

n/a

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

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

GOVERNANCE PRACTICE NOTE 001
APRIL 2026 (v.2)

TRUST SEAL

1. The Trust's Standing Orders at para 9.0 (see below) provides that the common seal of the Trust is only applied to documents where the board has approved a transaction to which the document relates, or separately approves the common seal being applied. This practice note articulates this process to ensure that this information is provided at the time a request to apply the common seal to a document is made, and to reiterate the signing and witnessing process.

2. The common seal is often required to be applied to deeds and legal documents such as transfers of land or lease agreements. The common seal is not always required for a document to be signed as a deed, and the instructions from the Trust's solicitors or NWSSP legal and risk team should be followed in all circumstances. Where there is doubt the Director of Corporate Governance/Board Secretary should be consulted on the correct process.

3. The following process should be followed where a document requires the Trust common seal:

   3.1. The requester completes the common seal proforma at Annex 1 and sends to the Director of Corporate Governance/Board Secretary and the relevant director with a copy of the document to be signed and sealed.

   3.2. Where the requester indicates the transaction to which the document relates has not been approved by the board, the board's approval to applying the common seal must be sought. It should be noted that such approval is not to approve the transaction – only the application of the seal to the document in accordance with standing order 9.0.1.

   3.3. Where board approval to the application of the common seal is required the Director of Corporate Governance/Board Secretary will advise the requester and the relevant Director of the next scheduled opportunity to do so. Where the document is required to be sealed before the next scheduled meeting of the board, the Director of Corporate Governance/Board Secretary will seek approval of the Chair and Chief Executive for a Chair's Action. However, all attempts must be made to provide notice to the Director of Corporate Governance/Board Secretary of the forward plan for leases and/or land related documents in particular to be sealed in accordance with the estates strategy and renewal programme.

3.4. The common seal is applied to the document by the Director of Corporate Governance/Board Secretary or a member of the Corporate Governance Team in the presence of the Chair and the Chief Executive (or their formal deputy). This may be done virtually where all parties are unable to meet in person.

3.5. The application of the common seal is noted in the register of seals and reported to the public Trust Board at the next opportunity. The Director of Corporate Governance/Board Secretary will ensure this note is provided as part of the Chair's Report to Trust Board.

4. Documents, whether they be leases, deeds or contracts, are signed in accordance with the Scheme of Reservation and Delegation that forms part of the standing orders. The Standing Orders v.9 provides as follows:

32. Seal The keeping of a register of seal and safekeeping of the seal	Chief Executive	Director of Corporate Governance/Board Secretary
33. Signing of Documents		
33.1. Legal Proceedings/Advice		
(a) Engage Trust's solicitors/legal advisor	Chief Executive	Relevant Director
(b) Documents connected with legal proceedings[6]	Chief Executive	Relevant Director
33.2. Documents which are required to be executed as a Deed[7]	Chief Executive	Relevant Director and Director of Corporate Governance/Board Secretary
33.3. Other Agreements/Contracts not required to be executed as a Deed	Chief Executive	Relevant Director
33.4. Agreements/Contracts where award approved by Board	Chief Executive	N/A
33.5. Lease Agreements[8]	Chief Executive	Director of Finance and Corporate Resources and Director of Corporate

6 May include but not be limited to consent orders, defences, and settlement agreements)
7 Refer to Governance Practice Note 001 for use of Trust Seal
8 Copies of all leases are to be kept once signed by the Estates Manager for property related leases and by the Board Secretary for all other leases/contracts

5. Recognising that WAST is a national service and that hybrid and flexible ways of working have embedded since the Covid-19 pandemic, signatories to documents may not always be present in the same location. Accordingly, where a document requires a wet signature, all attempts will be made to have both the relevant Director and the Director of Corporate Governance/Board Secretary present in person to sign the document; however where that is not possible, the Director of Corporate Governance/Board Secretary will witness the Director's signature virtually (via Microsoft Teams or other medium) and will sign the document separately. A record of such virtual signings will be kept by the Director of Corporate Governance/Board Secretary.

6. The Director of Corporate Governance/Board Secretary will keep a record of all sealings in the Register of Sealings. The Register is currently in hard copy form and kept securely with the common seal by the Director of Corporate Governance/Board Secretary. From 1 April 2022 the Register of Sealings will be recorded on an excel sheet and retained in the Corporate Governance Directorate shared drive.

<u>Extract from Standing Orders:</u>

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board or Committee of the Board.

9.02. Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1 Register of Sealing

9.1.1 The Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the Trust, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the Trust shall be kept securely by the Board Secretary.

Change Table

Change Date	By Whom	Change
3 March 2022	Audit Committee	v.1 approved
20 April 2023	Audit Committee	Annual review. No changes made.
28 April 2026	Audit, Risk and Assurance Committee	Cyclical review: minor updates and replacement of references to standing orders.

Review Table

Review Date	By Whom	Change
April 2028	Audit, Risk and Assurance Committee	

Approved by Audit, Risk and Assurance Committee 28 April 2026

ANNEX 1

<table>
<tr><th colspan="3">REQUEST FOR THE COMMON SEAL TO BE APLIED TO A DOCUMENT</th></tr>
<tr><td>Name of Requester</td><td colspan="2"></td></tr>
<tr><td>Name of Director</td><td colspan="2"></td></tr>
<tr><td>Date of request</td><td colspan="2"></td></tr>
<tr><td>Date by which document is required to be sealed</td><td colspan="2"></td></tr>
<tr><td>Type of document
(e.g., land transfer, lease agreement, deed)
Please provide a copy of the document to be sealed</td><td colspan="2"></td></tr>
<tr><td>Parties to the document</td><td colspan="2"></td></tr>
<tr><td colspan="3">Please Note: The Trust's Standing Orders provide that the common seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts.
The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board or Committee of the Board.</td></tr>
<tr><td rowspan="2">Has the transaction to which the document relates been approved by the Board? If so, a separate approval to apply the Trust Seal is not required. If not, the separate approval will be required.</td><td>Yes</td><td>Provide the date of Board approval:</td></tr>
<tr><td>No</td><td>If no, Board approval will be required. Refer to Board Secretary for advice</td></tr>
</table>

Approved by Audit, Risk and Assurance Committee 28 April 2026

GOVERNANCE PRACTICE NOTE 002
APRIL 2026 (v.4)

PRIVATE BOARD AND COMMITTEE MEETIINGS

1. The Trust Board and its committees, other than its Remuneration Committee, conduct as much of its formal business in public as possible to promote openness and transparency. However, some of the business conducted at these meetings may more appropriately need to be considered in private session.

2. Matters relating to the award of contracts, disciplinary matters and matters concerning staff or any identifiable patient information will usually be considered as unsuitable for discussion in public. Other issues are harder to identify in advance.

3. In determining which matters should be reserved for private session, consideration is given to whether the information to be discussed would be exempt from disclosure under the Freedom of Information Act 2000 (FOI Act). If information would be exempt, then it is likely that it should be considered during the private session.

4. This practice note outlines the situations most likely to apply to matters considered by the board and committees in private session, and the manner in which decisions made in private session are reported in the public session of the Board.

Matters considered appropriate for consideration in private session

5. The matters below relate to exemptions from the FOI Act; however, those marked with an * are subject to the public interest test. This means they will only apply if the public interest in withholding the information is stronger than the public interest in releasing it.

   5.1. **Investigations into conduct of employees or Board systems that aim at identifying any improper conduct on behalf of staff and/or protecting patients**[1]*.
   Examples may include disciplinary or legal investigations into members of staff, and personal data including patient identifiable information.

   5.2. **Drafts of documents, not in final form, which will be published in the future**[2]*.
   Examples may include draft consultation documents or draft business justification documents.

   5.3. **Issues, the discussion of which in public would be likely to inhibit the free and frank provision of advice**[3]*.
   Examples may include matters in the initial stages of enquiry; early stages of

[1] FOI s.31(1)(g)
[2] FOI s.22
[3] FOI s.36(2)(b)

Approved by Audit. Risk and Assurance Committee, 28 April 2026

strategic thinking; sensitive 'live' issues addressed or discussed in recommendations/advice from external organisations.

5.4. **Issues, the discussion of which in public would be likely to prejudice the effective conduct of public affairs**[4]*.
Examples may include issues the Board is 'working through', where discussion in public may cause concern/alarm, or discussions about future public consultations where the Board wants to manage the timing and manner in which disclosures are made.

5.5. **Information containing the personal data of any living patient, staff member or any other person if disclosure would not be fair to that person**[5].
Examples may include reports relating to the conduct of a particular employee, or serious Incident reports relating to a particular (living) patient.

5.6. **Information provided in confidence from another person or organisation, if releasing that information would lead to a successful claim for breach of confidence**[6].
Examples may include patient records (including of patients who are no longer living), and some technical information from suppliers.

5.7. **Legal professional privilege**[7]*.
Examples may include communications with solicitors and barristers, and information created in order to seek legal advice or to help prepare for a legal claim.

5.8. **Disclosure of the information would be likely to damage an organisation's commercial interests**[8]*.
Those interests may be those of the Board, one of its suppliers or one of its customers. Examples may include current pricing information contained in contracts or tenders Information that would damage the Board's negotiating position if disclosed.

5.9. **Information, disclosure of which is prohibited by law**[9].
An example may be information prohibited from disclosure by Court Order.

6. Special regulations apply to requests for environmental information (the Environmental Information Regulations 2004). Similar exemptions to those outlined above are found in the Environmental Information Regulations. If the information to be discussed by the board or committee relates to the board's estate, emissions, or decisions/policies likely to affect the environment, Directors should seek further guidance from the Director of Corporate Governance/Board Secretary.

[4] FOI s.36(2)(c)

[5] FOI s.40(2)
[6] FOI s.41
[7] FOI s.42
[8] FOI s.43(2)
[9] FOI s.44

7. The final decision on whether material shall be discussed in private or public session shall be made by the Chair and Chief Executive, having taken advice from the Director of Corporate Governance/Board Secretary and in accordance with this practice note.

8. The Director of Corporate Governance/Board Secretary will keep under review the nature and volume of business considered in private to maintain openness and transparency.

Recording and Reporting Matters Considered in Private Session

9. Minutes of public meetings will be approved at the next public session, and minutes of private meetings will be approved at the next private session.

10. When the board or a committee meets in private session it must formally report any decisions taken to the next meeting of the board in public session including identifying the costs and delivery risks relating to decisions made where appropriate. With respect to the board, such decisions will be reported in the Governance Report in public session. For committees, these will ordinarily be reported through the committee Chair's highlight report to the Board.

11. The Remuneration Committee meets exclusively in private session given the sensitive and confidential nature of its deliberations. Notwithstanding this, the Remuneration Committee will report on its work through the Chair's Committee Highlight Report, which, depending upon issues of sensitivity and confidentiality, may be presented in public and/or private session of the board.

Change Table

Date	By Whom	Change
3 March 2022	Audit Committee	v.1 approved
20 April 2023	Audit Committee	v.2 approved. Amendment to paragraph 9 to include identification of the costs and delivery risks of decisions made in private session, and reporting of decisions via the Governance Report.
June 2024	Audit, Risk and Assurance Committee	v.3 approved. Edits to provision 4.2 regarding clarification of draft documents, and update to Board Secretary's job title (to include Director of Corporate Governance).
April 2026	Audit, Risk and Assurance Committee	Cyclical review: changes to reflect current practices regarding reporting of minutes of the committees to the board.

Review Table

Date	By Whom	Change
April 2028	Audit, Risk and Assurance Committee	

GOVERNANCE PRACTICE NOTE 003
APRIL 2026 (v.3)

CHAIR'S ACTION

1. The Trust Board meets on a bi-monthly basis, however there will be times when urgent issues arise that require the approval of the Board between these scheduled meeting.

2. The Trust's Standing Orders at para 2.1 (see below) provides that such urgent approvals may be made by the Chair and the Chief Executive on behalf of the board, after first consulting with at least two other non-executive directors. Where the Chair and the Chief Executive are satisfied that a decision cannot wait until the next scheduled meeting and the Director of Finance and Corporate Resources has reviewed the request where financial approvals are sought, the following process will ordinarily be followed:

   2.1. A cover paper will be prepared by the relevant director in the same way as if the matter was to be decided at a scheduled board meeting. Reasons for urgency must be included in the paper.

   2.2. Whilst the standing orders calls for consultation with at least two non-executive directors, the Director of Corporate Governance/Board Secretary will circulate the paper and the request for Chair's Action to the full board by email (including non-executive directors, voting and non-voting directors, and trade union partners) to promote transparency.

   2.3. The email will include the recommendation(s) for approval and a request for responses within a particular time period. Where possible, that should be at least three working days, however in cases of extreme urgency that may be truncated with the approval of the Chair and Chief Executive.

   2.4. Once the deadline has been reached, the Director of Corporate Governance/Board Secretary will confirm the outcome to the full board.

   2.5. A note of the Chair's Action, together with copies of the email request and responses will be prepared by the Director of Corporate Governance/Board Secretary and stored on the shared drive for audit purposes.

   2.6. The Director of Corporate Governance/Board Secretary will ensure that a record of the Chair's Action is formally captured in the Chair's Report at the next meeting of the Trust Board for ratification, with such ratification captured in the minutes of that meeting. The reporting of such decisions may be delayed where the business would otherwise have been considered in private session and where the timing of the

reporting of decisions made in private session must be considered, before being reported in public session.

3. There may be occasions when the Chair and Chief Executive wish to convene a meeting to consider a Chair's Action request. On such occasions there shall be at least two Non-Executive Directors present, together with the Director of Finance and Corporate Resources, the Director of Corporate Governance/Board Secretary, and relevant Director.

Extract from Standing Orders:

2.1 Chair's action on urgent matters

2.1.1 *There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.*

2.1.2 *Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.*

Change Table

Date	By Whom	Change
3 March 2022	Audit Committee	v.1 approved
20 April 2023	Audit Committee	Annual review. No changes made.
07 June 2024	Audit, Risk and Assurance Committee	v.2 approved. Updates to Board Secretary's job title and addition of final sentence in provision 2.6 regarding disclosure of closed decisions.
28 April 2026	Audit, Risk and Assurance Committee	Cyclical review: minor updates.

Review Table

Date	By Whom	Change
April 2028	Audit, Risk and Assurance Committee	