

## Bundle Reading Room 2 December 2025

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<b>Risk ID</b> 223	<b>The Trust’s inability to reach patients in the community causing patient harm and death</b>	<b>Date of Review:</b>	01/10/2025	<b>TREND</b>	<b>OVERALL</b> 25 (5x5)				
		<b>Date of Next Review:</b>	01/11/2025	➡					
<b>IF</b> significant internal and external system pressures continue	<b>THEN</b> there is a risk of an inability and/or a delay in ambulances reaching patients in the community	<b>RESULTING IN</b> patient harm and death	<b>External (LxC)</b>			<b>Internal (LxC)</b>			
			<b>Inherent</b>	TBC	TBC	TBC	TBC	TBC	TBC
			<b>Current</b>	TBC	TBC	TBC	TBC	TBC	TBC
			<b>Target</b>	TBC	TBC	TBC	TBC	TBC	TBC

**Strategic objective 1: Providing the right care or advice, in the right place, every time**

Work has continued to contribute to the design and development of a different approach to the Trust’s highest scoring risks in a way that describes the internal and external controls, assurances and gaps which have been separated into those that the Trust manages and those that it monitors.

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

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

The way the data is being presented in themes and categories supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level. This working draft is for discussion purposes and to highlight the direction of travel. There is still work to be done on this document.

**DRAFT Risk Appetite Level – Open**

We are open to taking risks regarding changes to processes impacting the right care or advice. We understand that innovation and improvement may involve some risk, and we are prepared to embrace these opportunities to enhance our service delivery.

<b>EXECUTIVE OWNER</b>	Executive Director of Operations	<b>ASSURANCE COMMITTEE</b>	Quality, Safety and Patient Experience Committee
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**Risk Commentary**

**Lost Hours by Arrival Month Year**



This risk remains at the highest possible level, reflecting the enduring impact of significant ambulance handover delays at Emergency Departments and timely access to definitive care. The strategic implications for the Trust are considerable, with patient harm, deterioration, and poor experience continuing to generate regulatory scrutiny, including through Prevention of Future Deaths reports.

The Trust has implemented a mature and embedded internal control environment, underpinned by real-time clinical and operational oversight through the Operational Delivery Unit (ODU), the Clinical Safety Plan (CSP), and system-level escalation mechanisms such as REAP and national risk huddles. These controls are further supported by structured assurance mechanisms including internal and external incident reporting, compliance monitoring, and governance review processes.

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

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

Strategic mitigation therefore remains focused on both internal transformation and system-wide influence. The Trust continues to engage proactively with national and regional programmes - including the Six Goals for Urgent and Emergency Care - to support shared learning, alignment of expectations, and strengthened collective ownership of outcomes.

The received Audit Wales report into the effectiveness of unscheduled care arrangements across NHS Wales provides a critical external perspective on whole-system performance and identifies further levers to drive national consistency and accountability. Achieving the target risk score will ultimately rely on sustained partnership working, improved operational alignment across organisations, and the embedding of nationally agreed standards into routine delivery at every level of the system.

**The introduction of W45 from 1 October and the efforts made by the majority of Health Board in the preceding months is a welcome step. Several sites, including BCU however continue to be problematic with W45 improvements not yet realised.**

CONTROLS	ASSURANCES
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MONITOR - External	External <b>Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.</b>
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1. External Handover Improvement Group (NHS Exec)	1. Established handover improvement group led by the Director of Operations, NHS Exec to address persistent delays in ambulance handovers at Emergency Departments. The groups' purpose is to coordinate improvement plans across Health Boards, monitor compliance with national guidance and facilitate audits and performance tracking through NHS Exec oversight. <b>The introduction of W45 from 1 October and the efforts made by the majority of Health Boards in the preceding months, is a welcome step. A clinically led Handover-45 taskforce has been formed and workshops hosted by the NHS Wales Performance and Improvement are ongoing to support local improvement plans.</b>
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2. Welsh Health Circular	2. Setting national standards for 15-minute patient handover timeframe, clinical practice, quality governance and operational safety mandating actions like early warning score implementation and infection control whilst also embedding legal compliance through frameworks e.g Duty of Quality. Outcomes are primarily overseen by the Welsh Government through a combination of national audit programmes and governance frameworks. The External Handover Improvement Group has been established consider the elements of the Welsh Health Circular.
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3. Mitigating Avoidable Harm Actions	5. Actions were developed in direct response to persisting and escalating system pressures. The avoidable harm paper outlines a strategic framework to reduce patient risk with key measures including the clinical safety plan, Immediate release protocol and governance via the Serious Clinical Incident Forum (SCIF). Outcomes are monitored through risk scores, DATIX reporting, clinical audits and patient harm indicators. Actions were developed in direct response to persisting and escalating system pressures.
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MITIGATE - Internal <b>How do we know the controls are effective. How will these impact the target risk score?</b>	Internal <b>over the three lines of assurance. How do we know the assurances are effective</b> <b>Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk</b>
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<b>Control 1 – Policies/SOPs</b> Regional Escalation Protocol, Immediate Release Protocol v.1.3 (Released August 2024), Resource Escalation Action Plan (REAP – v5.1 released January 2025), Clinical Safety Plan (CSP – released December 2024).	<b>First Line of Assurance</b> Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly Performance, Demand and Capacity meetings to review REAP levels.	<b>Second Line of Assurance</b> ODU dashboards, Performance Demand and Capacity performance metrics data and DATIX and compliance reporting to the COO's.	<b>Third Line of Assurance</b> Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System Audit received June 25, actions being worked through.
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<b>Control 2 – Performance/Tactics</b> ETA Scripting, CCC Emergency Rule, Red call performance, Transfer of Care, ARA (Swansea and YGC), EMS Demand and Capacity Review.	<b>First Line of Assurance</b> Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly Performance, Demand and Capacity meetings to review REAP levels. Local Business Meetings performance discussions.	<b>Second Line of Assurance</b> ETA dashboard, UHP reporting in local and business meetings. ODU dashboards, Performance Demand and Capacity performance metrics data, MIQPR (Monthly Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly).	<b>Third Line of Assurance</b> Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System Audit received June 25, actions being worked through.
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<b>Control 3 – Operational Activities</b> National Risk Huddles, Performance, Demand and Capacity meetings, WAST Serious Clinical	<b>First Line of Assurance</b> Daily Risk Huddles, Weekly Performance Demand and Capacity Meetings, Local business meetings.	<b>Second Line of Assurance</b> Patient safety highlight reports. ODU Dashboards, Performance, Demand and Capacity performance metrics, MIQPR (Monthly	<b>Third Line of Assurance</b> Ministerial Advisory Group, NHS Exec Handover Group, Audit Wales investigation of Urgent and
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Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	01/10/2025	TREND	OVERALL 25 (5x5)
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Incident Forum (SCIF), Operational Handover Group		Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly).	Emergency Care System. Audit received June 25, actions being worked through.			
<b>Control 4 – Resources</b> 24/7 Operational Delivery Unit, Strategic, Tactical and Operational 24/7 system to manage escalation plans, APP (Advanced Paramedic Practitioner) deployment model, APP Navigation, CFR recruitment and deployment and CHARU implementation.	<b>First Line of Assurance</b> CSP review and escalation, On Call team start and end of shift, Performance, Demand and Capacity Meetings, Senior Leadership Team meetings.	<b>Second Line of Assurance</b> Shift reports, CSP review, On Call rota review, APP Dashboard, Volunteer performance highlight reporting.	<b>Third Line of Assurance</b> Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System. Audit received June 25, actions being worked through.			
<b>Control 5 – Clinical Model Transformation (CMT)</b> Consult and Close (including Mental Health Practitioners), Clinical review of code sets, Remote Clinical Support, Rapid Clinical Screening, expansion of See and Treat resources.	<b>First Line of Assurance</b> CPAS, DCR and CQGG Meetings, Clinical Model Transformation Project Board. Senior Leadership Team Meetings. Performance, Demand and Capacity Meetings.	<b>Second Line of Assurance</b> Performance, Demand and Capacity metric reporting, CPAS/DCR reporting, Volunteer highlight reporting, clinical model transformation highlight report.	<b>Third Line of Assurance</b> Audit Wales investigation of Urgent and Emergency Care System. Audit received June 25, actions being worked through.			
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>				
External		External				
1. Inconsistent compliance with 15-minute handover standard by Health Boards which is inconsistent with the National standard set out by the Welsh Health Circular. Although national guidance exists, adherence is variable across sites and Health Boards, limiting WAST's ability to fully mitigate risk independently. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.		1. While Health Boards have developed handover improvement plans, there is currently no routine, structured mechanism for independent review or validation of their implementation, progress, or effectiveness. External Scrutiny is primarily limited to periodic updates through forums such as IQPD or JCC which may not provide consistent assurance of impact. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework. <b>The W45 initiative, once embedded across all Health Boards, will help support to address this gap.</b>				
2. Operational pressures within Emergency Departments and inpatient areas continue to affect the ability of Health Boards to consistently adhere to the 15-minute handover expectation, despite the presence of national guidance. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.		2. There is limited independent scrutiny or assurance regarding how capacity pressures within Emergency Departments and inpatient settings are being addressed by Health Boards. These constraints directly affect handover performance but fall outside of WASTs operational control or influence. Limiting the Trust's ability to mitigate the risk independently. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.				
3. Local Delivery Units limited to 2 Health Board Areas (Hywel Dda and BCU)		3. Inconsistency with the Local Delivery Units being implemented in only two Health Boards however recognising that the LDUs within Hywel Dda and BCU are in their infancy with potential rollout Pan Wales dependant on the success of the measurable outcomes.				
5. Inconsistent pathways across Health Boards		5.				
4. Local Delivery Units – Hywell Dda and BCU		6. A model to replicate oversight and scrutiny across Health Boards, like the Trust's Operational Delivery Unit (ODU). Activity will be based on the System Escalation Framework actions complemented by Local Action Plans – Date of implementation of LDUs to be confirmed. Moved from Control to Gap in control - SLT will be content to move to control upon completion of implementation of LDUs.				
5. Ministerial Advisory Group (MAG)		7. Providing independent oversight of NHS Wales performance and recommending standardise clinical pathways to reduce delays and improve outcomes. MAG promotes better use of data to monitor patient safety, while its recommendations are embedded into national risk frameworks and Board Assurance processes to ensure system-wide impact. Moved to Gap currently - only 1 meeting has taken place so far. SLT content to move to control once meetings are fully established				
Internal		Internal				
1. Clinical Model Transformation (CMT) not fully implemented		1. Due to the implementation not being fully established there may be gaps in assurance meaning limited evidence currently or certainty that the controls are working as intended, however, as the model progresses the measurable outcomes will be reviewed and any concerns/issues addressed and monitored through actions. Current methods of monitoring the CMT includes CMT Project Board and an approved governance, reporting structure through T&F Groups.				
<b>Actions to reduce risk score or address gaps in controls and assurances</b>	<b>Action Owner (Internal only)</b>	<b>Completion / Milestone date</b>	<b>Progress Update</b>			
1. 6 weeks test of change Morryston	Sonia Thompson, Assistant Director of Operations		<b>OCT25 – Test of change now moved to BAU, discussions will be started within Swansea Bay to explore W45 options similar to Cardiff and Vale.</b>			

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			<p>July25 - Majority of test of change has remained, still seeing improvements in handover. Work ongoing with the Health Board looking at increase in front door attendance.</p> <p>Jun 25 – Currently in week 6 with average handovers remaining under 50 minutes. WAST qualitative and quantitative data has been shared with Health Boards to continue the trial.</p>			
2. Royal Glamorgan working to 45 minute handover	Sonia Thompson, Assistant Director of Operations		<p><b>OCT25 – No progressional update however the 2 CTM sites are still performing well in relation to Notification to Handover Performance.</b></p> <p>July25 - Ongoing progressing well, monitored locally, new measures put in place are being effective. Taking more of a risk at the front door and implemented a helicopter nurse</p> <p>Jun 25 – Handovers with average of 30 mins. Current ongoing discussion to rollout trial in other areas.</p>			
3. Clinical Model transformation (CMT) - 12 month pilot programme conducted to understand the full implications of the changes, identify issues and provide valuable insights into the effectiveness of the Clinical service model.	Pete Brown, Assistant Director of Operations, Integrated Care		<p><b>Oct25 - The Clinical Model Transformation (CMT) Programme is advancing care delivery with new 999 call categories launching in December to prioritise responses based on clinical needs, supported by new screening codes. The NHS111. Wales Virtual Assistant, Albot, has answered over 7,000 queries, with planned enhancements like multilingual capabilities. Community care is being strengthened through initiatives like a dedicated Falls Desk, Advanced Paramedic Practitioner scheduling, and an extended Mental Health Response Vehicle pilot. Digital health services are improving accessibility, and tools like the CMT Manager's Information Pack and Patient Personas are being developed to enhance understanding and keep patient experience central.</b></p> <p>July 25 - The Clinical Model Transformation Programme has made strong progress, including the launch of the Access to Transport for Planned Care initiative, improved emergency call handling with new categories and CAD updates, and the soft launch of the 111.Wales Virtual Assistant. Video consultations are now available for Integrated Care clinicians, and urgent care delivery is being enhanced through new scheduling models, improved Falls Services, and the evaluation of the Mental Health Response Vehicle trial—all contributing to a more responsive, patient-centred system.</p>			
4. Cross reference the IMTP 2025-27 plan/deliverables with Corporate Risk 223	Judith Bryce, Assistant Director of Operations, National Ops and Support	COMPLETE	<p><b>July25</b> – Cross checking complete, CMT holds more focussed approach to mitigating handover</p> <p>Jun 25 – this is planned for the IMTP assurance meeting on 14<sup>th</sup> July.</p>			
5. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	Chief Executive Officer	COMPLETE	<p><b>July25</b> – Audit received and actions being worked through. Audit Wales are supportive of the actions taken by WAST and there is positivity received on what WAST are doing.</p> <p>Jun 25 – Awaiting report from Audit Wales</p> <p>May 25 – Awaiting report from Audit Wales which will come through Audit Committee.</p>			

<b>Risk ID</b> 224	<b>Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe &amp; Effective Service for Patients</b>		<b>Date of Review:</b>	03/10/2025			<b>TREND</b>	<b>OVERALL</b> 25 (5x5)	
			<b>Date of Next Review:</b>	03/10/2025			➔		
<b>IF</b> patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	<b>THEN</b> there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	<b>RESULTING IN</b> patients coming to significant harm and a poor patient experience	<b>External (LxC)</b>			<b>Internal (LxC)</b>			
			<b>Inherent</b>	TBC	TBC	TBC	TBC	TBC	TBC
			<b>Current</b>	TBC	TBC	TBC	TBC	TBC	TBC
			<b>Target</b>	TBC	TBC	TBC	TBC	TBC	TBC
<p><b>Strategic objective 1: Providing the right care or advice, in the right place, every time</b></p> <p>Work has continued to contribute to the design and development of a different approach to the Trust's highest scoring risks in a way that describes the internal and external controls, assurances and gaps which have been separated into those that the Trust manages and those that it monitors.</p> <p>The next steps will include testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death.</p> <p>Each of the assurances against the controls have been described over three lines of assurance. A future piece of work will be undertaken to score the effectiveness of these controls and assurances.</p> <p>The way the data is being presented in themes and categories supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level. This working draft is for discussion purposes and to highlight the direction of travel. There is still work to be done on this document.</p>									
<p><b>EXECUTIVE OWNER</b> Executive Director of Quality and Nursing</p> <p><b>ASSURANCE COMMITTEE</b> Quality, Patient Experience and Safety Committee</p>									
<p>This risk remains at the highest possible level, reflecting the enduring impact of significant ambulance handover delays at Emergency Departments on timely access to definitive care. The strategic implications for the Trust are considerable, with patient harm, deterioration, and poor experience continuing to generate regulatory scrutiny, including through Prevention of Future Deaths reports.</p> <p>The Trust has implemented a mature and embedded internal control environment, underpinned by real-time clinical and operational oversight through the Operational Delivery Unit (ODU), the Clinical Safety Plan (CSP), and system-level escalation mechanisms such as REAP and national risk huddles. These controls are further supported by structured assurance mechanisms including internal and external incident reporting, compliance monitoring, and governance review processes.</p> <p>Phase one of the Trust's Clinical Transformation Model - specifically the introduction of Code Changes for response - has now gone live, representing a key milestone in the delivery of an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. In parallel, early adoption of the <i>Wait 45</i> handover standard by some Health Boards represents a positive step toward reducing avoidable patient harm by supporting more timely transfers of care and improving the overall experience for patients awaiting treatment.</p> <p>While the Trust continues to demonstrate high levels of internal assurance, recent national focus on care standards and system performance provides a welcome opportunity to strengthen consistency and improve the effectiveness of wider system responses. Historic variation in adherence to national handover standards and the delivery of improvement plans has limited the extent to which the Trust can mitigate this risk through internal controls alone. However, increasing national scrutiny, greater transparency, and a shift toward more integrated, system-based accountability present a clear opportunity to improve consistency and collective impact across organisational boundaries.</p> <p>Strategic mitigation therefore remains focused on both internal transformation and system-wide influence. The Trust continues to engage proactively with national and regional programmes - including the Six Goals for Urgent and Emergency Care - to support shared learning, alignment of expectations, and strengthened collective ownership of outcomes.</p> <p>The Audit Wales report into the effectiveness of unscheduled care arrangements across NHS Wales will provide a critical external perspective on whole-system performance and may identify further levers to drive national consistency and accountability. Achieving the target risk score will ultimately rely on sustained partnership working, improved operational alignment across organisations, and the embedding of nationally agreed standards into routine delivery at every level of the system. The persistence of long handover delays also has a secondary impact on staff wellbeing, contributing to moral injury, stress and frustration at being unable to provide timely care. This interlinks with Risk 558 (staff wellbeing), underlining the wider organisational and cultural impact of this risk.</p>									
<p><b>DRAFT Risk Appetite Level – Open</b></p> <p>We are open to taking risks regarding changes to processes impacting the right care or advice. We understand that innovation and improvement may involve some risk, and we are prepared to embrace these opportunities to enhance our service delivery.</p>									

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	03/10/2025	TREND	OVERALL 25 (5x5)
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<b>CONTROLS</b>		<b>ASSURANCES</b>			
MONITOR - External		External <b>Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.</b>			
1. <b>Welsh Health Circular WHC/2024/041: NHS Wales Hospital Handover Guidance (15-minute standard)</b> National directive setting out compliance expectations for handover of care within 15 minutes. WAST operates in alignment with this standard, however the operational responsibility for implementation and compliance lies primarily with Health Boards. As such, this constitutes an external control which influences WAST risk exposure but sits outside the Trust's direct control.	1. Real-time ODU oversight and Clinical Safety Plan escalation where patients are delayed beyond 15 minutes, with clinical risk managed via NEWS triggers and local management actions. Handover performance reported via IQPR and discussed through SLT and Quality Governance forums. Trends, outliers, and sustained delays are highlighted and tracked over time.  Oversight by Welsh Government through the Six Goals Programme and Joint Commissioning Committee. Handover compliance is also subject to scrutiny through national audit programmes (e.g. Audit Wales), and regulatory inspections (e.g. HIW).				
2. <b>Six Goals for Urgent and Emergency Care Programme</b> Goal 4 <i>Rapid response in physical or mental health crisis</i> . The quality statement for this goal includes: Those arriving by ambulance at a hospital facility should be transferred safely from ambulance clinicians to the care of hospital clinicians in order of clinical priority and always in a timely manner (an hour at most).	2. Organisational performance is monitored externally through Six Goals Programme Board, Quality and Delivery Board, Integrated Quality, Planning & Delivery (IQPD) meetings, Joint Executive Team (JET) meetings, NHS Performance Board and managed within the NHS Wales Oversight and Escalation Framework.				
3. <b>NHS Wales Performance Framework 2024-25</b> Measures 52 and 53 provide the expected performance targets in respect of ambulance handover timescales: 52. Number of ambulance patient handovers over one hour 53. Percentage of ambulance patient handovers within 15 minutes	3. Organisational performance is monitored externally through Quality and Delivery Board, Integrated Quality, Planning & Delivery (IQPD) meetings, Joint Executive Team (JET) meetings, NHS Performance Board and managed within the NHS Wales Oversight and Escalation Framework.				
4. <b>NHS Wales Quality and Safety Framework and Duties of Quality and Candour</b> The National Quality Management System (NQMS) brings together data from a number of sources, including patient safety incidents, for triangulation and to inform a range of activities in relation to learning and quality and governance assurance. The duty of quality in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ("the 2020 Act") has two aims - to improve the quality of services, and to improve outcomes for people in Wales. Together, the domains of quality and quality enablers create the health and care quality standards 2023.	4. Organisations provide statutory reporting against the Duties of Quality and Candour. National ED survey on Civica People Experience platform, results are monitored on a national Quality and Safety dashboard (Beacon)				
5. <b>Nationally led operational escalation responses</b> Risk Huddles, hospital escalation levels and daily national operational call					
MITIGATE - Internal <b>How do we know the controls are effective. How will these impact the target risk score?</b>		Internal <b>over the three lines of defence. How do we know the assurances are effective</b> <b>Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk</b>			
<b>Control 1: Policies/SOPs/Resources</b>  Regional Escalation Protocol, Immediate Release Protocol v.1.3 (Released August 2024), Resource Escalation Action Plan (REAP – v5.1 released January 2025), Clinical Safety Plan (CSP – released December 2024).  The CSP provides a structured, tiered framework for managing operational and clinical safety risks, including delayed handovers. It is supported by the 24/7 ODU, which ensures real-time oversight, escalation, and action planning. Together, they act as core controls to dynamically mitigate risk, coordinate escalation across the system, and support staff in delivering safe care under pressure. These are real-	<b>First Line of Assurance (Operational)</b>  ODU shift reports, CSP real-time updates, REAP actions logged and enacted in real time; daily huddle notes and agreed actions monitored by Operational Delivery Unit	<b>Second Line of Assurance (Internal Monitoring)</b>  Senior Leadership Team (SLT) weekly review of Resource Escalation Action Plan (REAP), Integrated Quality and Performance Report (IQPR)	<b>Third Line of Assurance</b>  JCC and IQPD reporting.  Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (report from Audit Wales received and actions being worked through)		

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<p>time, operational risk management controls that actively shape outcomes, especially in the face of delayed care environments.</p> <p>REAP outlines predefined escalation actions aligned to risk levels and is reviewed weekly by the SLT. National and local risk huddles enable shared situational awareness, trigger cross-system escalation, and ensure timely mitigation actions are documented and followed up.</p>					
<p><b>Control 2: Clinical Guidance for staff</b></p> <p>A Clinical Guidance document for WAST clinicians delayed outside the Emergency Department provides direction to WAST clinicians when asked to support care of a patient awaiting their care to be handed over to the hospital. The guidance ensures safe and appropriate clinical management within appropriate scopes of clinical practice.</p> <p>The Clinical Notice 07/2021 <i>Escalating a clinical concern with a deteriorating patient outside the Emergency Department</i> instructs staff to raise concerns with the Nurse in Charge of the Emergency Department and provides information on the internal escalation process through the DOM via EMSC, and then for senior clinical support via the on-call system. Clinical risk-triggered escalation using NEWS <math>\geq 5</math> for patients is reinforced via national clinical notices.</p>	<p><b>First Line of Assurance (Operational)</b></p> <p>Datix incident reporting of any cases where clinical concerns are escalated. Incident management processes are followed in accordance with the Trust's Adverse Incident Policy.</p> <p>Compliance with mandatory training and competency standards</p>	<p><b>Second Line of Assurance (Internal Monitoring)</b></p> <p>Oversight of incident management and learning through Ambulance Practice Steering Group (APSG), Clinical Quality Governance Group and QuEST.</p>	<p><b>Third Line of Assurance</b></p> <p>National reporting of high severity incidents.</p> <p>Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (report from Audit Wales received and actions being worked through)</p>		
<p><b>Control 3: Clinical Governance mechanisms</b></p> <p>Prompt and responsive learning from concerns (complaints and incidents) or from mortality reviews related to patient harm during delayed handover of their care should inform continuous system improvements.</p> <p>Incidents, complaints or medical examiner scrutiny referrals resulting in serious harm to a patient are reviewed at the Trust's Serious Case Incident Forum. Where harm may be attributed to delays in being able to handover their care at the Emergency department, cases are shared with the respective Health Board of patient residence to review the measures undertaken at the time of the delay to minimise risk and to identify opportunities to reduce harm in future. This is in line with <i>Section 4 Joint investigation process of the National Policy on Patient Safety Incident Reporting (May 2023)</i>.</p> <p>Learning from these incidents should be shared with the Trust once the Health Board has completed their investigation.</p> <p><b>Frequent responsive learning from concerns (complaints and incidents), mortality reviews, and medical examiner scrutiny is essential to driving continuous system improvements in relation to patient harm during delayed handovers of care. The Clinical Advisory Group (CAG) provides a critical forum for clinicians to review a selection of these cases, test learning against national clinical standards, and ensure professional oversight of system risks and mitigations before they are escalated to governance committees.</b></p>	<p><b>First Line of Assurance (Operational)</b></p> <p>Incident reports (Datix); regular meetings to capture learning medical examiner referrals; SCIF meeting records; immediate actions taken and documented in safety briefings.</p> <p>The Clinical Advisory Group (CAG) reviews complex or high-risk cases related to delayed handovers, provides peer clinical scrutiny, triangulates themes from Datix, SCIF, complaints and medical examiner referrals, and advises on pathway changes. It also acts as the key clinical forum to escalate patient safety concerns, ensuring that frontline clinical voice is embedded into decision-making and that assurance is provided to CQGG on learning effectiveness</p>	<p><b>Second Line of Assurance (Internal Monitoring)</b></p> <p>Reporting to Clinical Quality Governance Group (CQGG); assurance papers to QuEST and other Board Committees</p> <p><b>Reporting to Clinical Quality Governance Group (CQGG), with CAG acting as a feeder forum to provide clinical triangulation and assurance.</b></p> <p><b>Assurance papers to QuEST and other Board Committees.</b></p>	<p><b>Third Line of Assurance</b></p> <p>NHS Wales Internal Audit, external reporting of severe harm incidents (Nationally Reportable Incidents).</p> <p>Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (report from Audit Wales received and actions being worked through)</p>		
<p><b>Control 4: Implementation of Duty of Quality, Candour &amp; Quality Standards</b></p> <p>Internal governance structures, led by the Clinical Quality Governance Group and operationalised through the Quality Management Group (QMG), provide a structured approach to embedding statutory duties. These frameworks act as corporate controls to ensure care quality, transparency, and continuous</p>	<p><b>First Line of Assurance (Operational)</b></p> <p>Compliance with statutory reporting duties – training and awareness uptake</p>	<p><b>Second Line of Assurance (Internal Monitoring)</b></p> <p>Monthly updates through Quality Management Group (QMG)?</p>	<p><b>Third Line of Assurance</b></p> <p>Welsh Government assurance through Duty of Candour/Duty of Quality annual reporting.</p>		

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	03/10/2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	03/10/2025		
<p>improvement, particularly during periods of operational pressure such as delayed handovers.</p> <p>Where patient harm is identified during delayed handovers, Duty of Candour requirements are triggered. These are reported both internally via CQGG and externally through statutory annual reporting to Welsh Government. This ensures that harm events linked to delayed handovers are subject to openness, patient/family communication, and system-wide accountability.</p> <p>The Patient Harm Mitigation Report (bi-monthly) provides a standing review of handover-related harm cases, trends in medical examiner referrals, and the outcomes of SCIF reviews. This forms part of the evidence base considered by CQGG and QuEST in providing internal assurance.</p>		<p>Monitoring via CQGG</p> <p>Quality dashboard under development</p>		<p>Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (report from Audit Wales received and actions being worked through)</p>	
<p><b>Control 5: Clinical Model Transformation (CMT)</b> Consult and Close (including Mental Health Practitioners), Clinical review of code sets, Remote Clinical Support, Rapid Clinical Screening, expansion of See and Treat resources.</p>		<p><b>First Line of Assurance (Operational)</b> CPAS, DCR and CQGG Meetings, Clinical Model Transformation Project Board. Senior Leadership Team Meetings. Performance, Demand and Capacity Meetings.</p>		<p><b>Second Line of Assurance (Internal Monitoring)</b> Performance, Demand and Capacity metric reporting, CPAS/DCR reporting, Volunteer highlight reporting, clinical model transformation highlight report.</p>	
				<p><b>Third Line of Assurance</b> Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (report from Audit Wales received and actions being worked through)</p>	
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>			
External		External			
1. Inconsistent compliance with 15-minute handover standard by Health Boards Although national guidance exists, adherence is variable across sites and Health Boards, limiting WAST's ability to fully mitigate risk independently.		1. While <b>Health Boards have developed handover improvement plans, there is currently no routine, structured mechanism for independent review</b> or validation of their implementation, progress, or effectiveness. External scrutiny is primarily limited to periodic updates through forums such as IQPD or JCC, which may not provide consistent assurance of impact.			
2. Operational pressures within Emergency Departments and inpatient areas continue to affect the ability of Health Boards to consistently adhere to the 15-minute handover expectation, despite the presence of national guidance.		2. There is limited independent scrutiny or assurance regarding how capacity pressures within Emergency Departments and inpatient settings are being addressed by Health Boards. These constraints directly affect handover performance but fall outside of WAST's operational control or influence, limiting the Trust's ability to mitigate the risk independently.			
Internal		Internal			
1. There is no structured or independent mechanism to validate the effectiveness of Health Board actions in response to delayed handover harm cases shared by WAST. Assurance remains dependent on Health Board feedback and periodic forums (e.g., IQPD/JCC), which do not consistently evidence impact		1. Routine audit of patient deterioration and management during delayed handovers is not yet embedded across all sites, limiting the ability to quantify the full scale of harm and test the effectiveness of mitigation			
2.		2. Improved reporting on outcomes of joint investigations - there is no structured or independent mechanism to validate the effectiveness of Health Board actions in response to delayed handover harm cases shared by WAST. Assurance remains dependent on Health Board feedback and periodic forums (e.g., IQPD/JCC), which do not consistently evidence impact. This is an assurance gap that Audit Wales and Ministerial Advisory Group may help close			
<b>Actions to reduce risk score or address gaps in controls and assurances</b>		<b>Action Owner (Internal only)</b>		<b>Completion / Milestone date</b>	
				<b>Progress Update</b>	
1. Contribution to the development of a national joint investigation learning repository		Assistant Director of PTR		Q1 2026	
				Pilot of the new module being undertaken with WAST and Cardiff and Vale UHB <b>14.8.25: Pilot completed with Cardiff and Vale. Evaluation Meeting to take place in September 2025</b>	

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:		03/10/2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:		03/10/2025		
2. Clinical Model transformation (CMT) - 12-month pilot programme conducted to understand the full implications of the changes, identify issues and provide valuable insights into the effectiveness of the Clinical service model.	Assistant Director of Operations, Integrated Care	Q2 2026	01.07.2025 - Go Live implementation commenced 1 <sup>st</sup> July - phase one, code changes <b>July 25 Update: Strong progress continues across the Clinical Model Transformation Programme, with key milestones including improved 999 call categorisation, launch of the 111 Virtual Assistant, video consultations in Integrated Care, and enhanced urgent care through new scheduling, Falls Services, and the Mental Health Response Vehicle trial</b>			
3. Cross reference the IMTP 2025-27 plan/deliverables with Corporate Risk 224	Deputy Director of Nursing, QSPE	<b>COMPLETE</b>	14.8.25: Cross reference action complete			
4. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	Chief Executive Officer		May 25 – Awaiting report from Audit Wales which will come through Audit Committee. <b>14.8.25: Report received and identified recommendations to be completed</b>			

<b>Risk ID</b> 201	A loss of stakeholder confidence that damages the Trust reputation			<b>Date of Review:</b>	28/05/2025	<b>TREND</b>	20 (4x5)
				<b>Date of Next Review:</b>	28/06/2025	➔	
<b>IF</b> there is an inability of the Trust to deliver its core services because of system or organisational pressures	<b>THEN</b> there will be a loss of stakeholder confidence in the Trust	<b>RESULTING IN</b> a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny			<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
				<b>Inherent</b>	4	5	20
				<b>Current</b>	4	5	20
				<b>Target</b>	3	5	15
IMTP Deliverable Numbers: 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 16, 25, 27							
Strategic Objective:							
<b>EXECUTIVE OWNER</b>	Director of Partnerships and Engagement	<b>ASSURANCE COMMITTEE</b>	People and Culture Committee				
<b>Risk Commentary</b> Q1 2025/26							
This risk has been scored at 20 for some time, and has proven difficult to de-escalate, given performance challenges and the levels of harm experienced by some patients. It has become increasingly apparent that there are differential risks inherent in what is currently described as a single risk, e.g. the Trust's reputation with Welsh Government and commissioners is in a relatively stable position, but this is not necessarily the case with other stakeholders, nor with some patient groups where harm is most prevalent. On that basis, a deep dive review will be undertaken to determine how this risk could be reprofiled to provide a more accurate assessment of the reputational risk facing the organisation. This is likely to result in the disaggregation of the current risk, ensuring the risk definition and mitigation are appropriately differentiated and withstand scrutiny. At this stage, it is anticipated that the review will be completed by the end of Q2, with ADLT supporting the Director of Partnerships and Engagement in the deep dive process. Any amended risk(s) will be included in an updated Board Assurance Framework and will be reported through the usual governance routes.							
<b>CONTROLS</b>				<b>ASSURANCES</b>			
				<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. CEO and DSP meeting with HB CEOs throughout Q4 to informally discuss strategic ambition				1. Feedback reported via ELT, CMT etc			
2. Revised engagement framework delivery plan is now described as the programme engagement plan and continues to be updated and revised to reflect feedback from stakeholders and revised timelines for strategy engagement				2. Reported at CMT at each meeting on who has been engaged with and risks that are emerging etc			
3. Challenging of media reports to ensure accuracy.				3. Programme of daily media engagement documented on digital system			
4. Media liaison to ensure relationships developed with key media stakeholders				4. Programme of daily media engagement documented on digital system			
5. Routine stakeholder and staff engagement and WAST Live.				5. Agendas, minutes, and documents of engagement events. Informal feedback via ELT and reported via Trust Board (CEO update)			
6. Engagement governance and reporting structures are in place				6. Relevant information which impacts on reputation is reported and scrutinised via all internal committees e.g., ELT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs.			
7. Annual deep dives on reputation have been undertaken 2024/25.				7. Was reported to Committees, documented in minutes, action logs and papers			
8. Engagement of the Board on matters of reputation in development sessions. If required, escalation procedure for issues to the Board where circumstances dictate, following discussion at ELT				8. Minuted meetings, action logs and Board papers			
9. Regular engagement with senior stakeholders e.g., Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders				9. Informal feedback reported via ELT and occasionally in formal correspondence (nature of discussion often precludes formal recording)			
10. Monitoring external factors that may affect the Trust				10. ELT verbally updated on a regular basis with written notes if appropriate			
11. Board oversight, scrutiny and challenge of performance, concerns, quality				11. Minuted meetings, action logs and Board papers			
12. Internal Quality and Performance monitoring in the Trust and raising system issues				12. Data provided though reporting to Committee and Board for scrutiny and feedback.			
13. Reputation audit launched on 09 April 2024 and ran until 01 May 2024.				13. High-level results presented at People and Culture Committee on 09 May and at Board Development on 27 June to assist the Trust to understand the impact of the reputation audit and to support our approach to stakeholder engagement.			
14. Development of a Winter Media Plan				14. Monitored daily by the team and updated based on media coverage and public sentiment.			
<b>GAPS IN CONTROLS</b>				<b>GAPS IN ASSURANCE</b>			
1. Managing the narrative of the media				1.			
2. Strategic collaboration – further work needed to formalise opportunities – to think about how this translates into an action				2.			
<b>Actions to reduce risk score or address gaps in controls and assurances</b>	<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>				
1. Roll out of Programme Engagement Plan	Director of Partnerships & Engagement	Q4 24/25 Q1 25/26 and continued	Roll out underway.				
2. Board Development Session on political landscape	Director of Partnerships & Engagement	Q3-4 2025/26	To be finalised in the programme.				

<b>Risk ID</b> 641	<b>The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident</b>		<b>Date of Review:</b>	01/10/2025	<b>TREND</b>	20 (4x5)
			<b>Date of Next Review:</b>	01/11/2025	→	
<b>IF</b> the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared	<b>THEN</b> there is a RISK that the Trust's Incident Response will be suboptimal	<b>RESULTING IN</b> avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability.		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
			<b>Inherent</b>	5	5	25
			<b>Current</b>	4	5	20
			<b>Target</b>	2	3	6
IMTP Deliverable Numbers:						
Strategic Objective:						
<b>EXECUTIVE OWNER</b>	Executive Director of Operations	<b>ASSURANCE COMMITTEE</b>	Finance & Performance Committee			
<b>Risk Commentary</b>						
<p>Following the Manchester Arena Incident in May 2017, whereby twenty-two (22) innocent people were sadly killed, and the subsequent Public Inquiry (MAI), ambulance services across the UK have reviewed their ability to respond to a Major Incident. WAST has undertaken its own review and has identified sixty-eight (68) of the MAI recommendations as being pertinent to the ambulance service and/or multi-agency preparedness and response. Once these recommendations have been implemented then the risk will be mitigated to target; however, additional financial resources are required to do this.</p> <p>As part of the Trust's ongoing commitment to deliver the necessary change against the MAI recommendations, a dedicated team was established in June 2023 to investigate and assure the Board that all necessary organisational processes were in place should an incident occur in Wales. Since the beginning of this project, significant progress has been made in addressing the recommendations (as identified in the 'Controls' section below) and the Trust is better prepared because of the work undertaken to date.</p> <p>As part of the ongoing work, the Trust has completed a series of investigations and developed a series of 'Capability Reports' to demonstrate and explain where remaining challenges to an anticipated Major Incident could occur. The capability gaps identified are detailed in the below reports, which were shared with the Board, and are supported by a significant base of evidence produced as part of the 'R105' self-review process. The reports are:</p> <ul style="list-style-type: none"> <li>- <b>R106 Capability Report</b></li> <li>- <b>Capability to Prepare</b></li> <li>- <b>Capability to Respond</b></li> <li>- <b>Capability of Specialist Assets</b></li> </ul> <p>The reports identify that a significant proportion of the MAI recommendations remain outstanding, and the Trust is unable to progress these further or fully implement the identified learning without financial support. The reports highlighted what is needed to complete or significantly progress twenty (20) MAI recommendations and forms the basis of the 'Gaps in Controls' and 'Actions' sections. Transitioning these gaps and actions across into the 'Controls' section when achieved will act as a longitudinal method of tracking progress of completion against the MAI recommendations, and the associated risk reduction as this occurs. If the Trust is unable to implement the MAI recommendations fully, there remains a risk to the public, the organisation, and commissioners in the event of a mass casualty incident.</p> <p><i>This Board Assurance Framework (BAF) extract is supported by a more detailed appendix of itemised actions required to permit greater scrutiny of remaining gaps and actions, as well as a detailed repository of control measures that have been successfully implemented.</i></p>						
<b>CONTROLS</b>			<b>ASSURANCES</b>			
			<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. <b>Forty-six (46)</b> of the pertinent MAI Recommendations have been implemented into WAST practice through the work undertaken to date.			1. MAI recommendations that have been marked as implemented by the EPRR MAI Project are authorised and ratified by Operations Senior Leadership Team and cascaded via the approved governance route (AAA) to ELT and Trust Board. This forms a documented governance route for rationale for completion and details of this are recorded in the EPRR share drive alongside evidence of compliance. Additional details of assurance are provided in the annex to this Corporate Risk. Ongoing monitoring and assurance of lessons learned is captured through BAU processes and the established debriefing/lessons learned process such as the Organisational Learning Spreadsheet.			
<b>GAPS IN CONTROLS</b>			<b>GAPS IN ASSURANCE</b>			
1. Two (2) outstanding MAI Recommendations, identified as pertinent to WAST by the self-assessment, require action against to implement the associated learning ( <b>REF: MAI recommendations 26 &amp; 88</b> ). These are not included in the R106 funding request.			1. Work is progressing against these recommendations as part of the ongoing MAI project. It is anticipated that these recommendations can be implemented without additional financial support. Regular updates on these four recommendations are provided through the regular 'touch point' meetings with EPRR HoS, ADO for National Operations & ED of Ops, with periodic updates to SLT that are then cascaded via the approved governance route.			

Risk ID 641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Date of Review:	01/10/2025	TREND	20 (4x5)
		Date of Next Review:	01/11/2025	→	
2. Eighteen (18) outstanding MAI Recommendations that have been submitted to Trust commissioners via the 'R106' process as requiring financial support to implement the learning (REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 108, 109, 117, 124).	2. The outstanding recommendations are not able to be implemented independently by WAST and may remain unresolved until such time that additional financial resources and practical arrangements are in place to support this work. Trust commissioners have been notified of this via the formal R106 submission completed in August 2024.				
Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:		
1. Implement the learning relating to forty-eight (48) recommendations identified in the MAI report as pertinent for WAST (REF: Outstanding MAI recommendations (26 & 88)).	Assistant Director of Operations, National Operations & Support	CLOSED	<p>This programme of work is underway, with nearly all recommendations completed. 2 recommendations remain outstanding, with a plan in place to implement all these recommendations.</p> <p>May 25 – Progress report has been submitted to SLT and outstanding actions are now monitored through the risk register (Ref: 641). Submission to commissioners and further scrutiny sessions completed and awaiting commissioner outcome expected in August 2025.</p>		
2. Submit evidence to Commissioners demonstrating that additional funding is required to implement a further twenty (20) recommendations identified in the MAI report (REF: MAI recommendation R106).	Assistant Director of Operations, National Operations & Support	CLOSED	<p>March 25- During March and April the Trust has engaged with commissioners on a series of scrutiny sessions to review content of submission for the MAI; following these scrutiny sessions it will be for the commissioners to formally respond to the Trust, determining next steps and any subsequent course of action.</p> <p>A formal submission of requirements has been submitted to commissioners for consideration and approval. Commissioners have been engaged with since early 2024 to raise awareness and facilitate early discussion. The Trust is awaiting a formal response to the submission.</p> <p>May 25 – Progress report has been submitted to SLT and outstanding actions are now monitored through the risk register (Ref: 641). Submission to commissioners completed and awaiting commissioner outcome expected August 2025.</p> <p><b>Oct25 – A series of scrutiny sessions with Commissioners has been undertaken, the most recent being in September 2025. The Commissioner has provided a timescale to respond to the submission as being November 2025.</b></p>		
3. Implement the necessary amendments to Trust infrastructure, resourcing level and equipment required to address the remaining recommendations once funding has been made available. (REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 108, 109, 117, 124).	Assistant Director of Operations, National Operations & Support	March 2029	<p>An assortment of 20 proposals rests with commissioners at present. As these proposals are funded, capabilities gaps will be addressed and an associated reduction in the risk score can be expected. Some of these proposals may take several years to implement (e.g. a North Wales HART Unit) which is reflected in the target date. Other proposals could be accomplished in a much shorter timeframe if funded.</p> <p>Once the implementation of infrastructure, resourcing and equipment has occurred, WAST will either be compliant with the MAI recommendations, or, in some circumstances, may need to undertake further work to integrate the MAI learning into practice (e.g. once the EPRR Training &amp; Exercising Team have established, they will then need to provide sufficient levels of exercising to comply with the exercising-related MAI recs).</p>		

<b>Risk ID</b> 160	<b>High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service</b>			<b>Date of Review:</b>	15/10/2025	<b>TREND</b>	16 (4x4)
				<b>Date of Next Review:</b>	15/11/2025		
<b>IF</b> there are high levels of absence e.g., sickness and alternative duties.	<b>THEN</b> there is a risk that there is reduced resource capacity	<b>RESULTING IN</b> an inability to deliver services which adversely impacts on quality, safety, and patient/staff experience			<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
				<b>Inherent</b>	4	4	16
				<b>Current</b>	4	4	16
				<b>Target</b>	3	4	12
IMTP Deliverable Numbers: 13, 14, 15, 22, 24, 25, 26							
Strategic Objective:							
<b>EXECUTIVE OWNER</b>		Director of People		<b>ASSURANCE COMMITTEE</b>		People and Culture Committee	
<b>Risk Commentary</b>							
Sickness absence remains one of the key challenges for the organisation. Whilst there has been a significant reduction in absence levels over the past 18 months, rates remain higher than desired and therefore a continued focus on supporting good attendance at work is needed by both managers and the People and Culture team. Increased pressures on our people like handover delay, missed breaks and cost of living impact on health and wellbeing. The Health and Wellbeing Plan 2025-2029 and People and Culture Plan 2023-2026 provide strategic direction for relevant initiatives. The risk has been reviewed and the Likelihood score reduced to 4 from the current 5 therefore reducing the overall score from 20 to 16. It is recognised that the rolling annual figures for sickness since March 2022 are reducing year on year and therefore a reduction in the score is appropriate. This will be closely monitored by the People & Culture team and Executive Leadership Team.							
<b>CONTROLS</b>				<b>ASSURANCES</b>			
				<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. Significant policy frameworks and strategies embedded across the organisation including Managing Attendance at Work Policy, R&R, Speaking Up and the Health and Wellbeing Plan in place and followed with support from the P&C team.				1. (a) Audits undertaken by People Services Team (b) Outputs reviewed (c) Process reviews (d) PS team engagement on additional activities which could be delivered (e) Case support, advice and guidance with action planning to reduce absence  R&Rs addressed in timely way to reduce risks of sickness absence. Compassionate Practices approach engaged. Referral of colleagues to appropriate levels of support  Policy reviews to ensure policies and procedures are fit for purpose in line with agreed time frames Completed - 28/11/23 Speak Up Safely process introduced from the start of October 2023 including the appointment of one Trust guardian. The Health and Wellbeing Plan 2025-2029 and People and Culture Plan 2023-2026 provide strategic direction for initiatives to improve the workplace, in line with HEIW Best Practice Guide for Organisations. These documents support us in ensuring that our offer is focused, and evidence driven.			
2. Operational Workforce Recruitment Plans, roster reviews and implementation to actively address demand and capacity and ensure sufficient resources to meet workload pressure				2. Maintenance of the workforce establishment to seek to ensure that colleagues are not unnecessarily stretched through vacancies			
3. Return to Work interviews are undertaken - SharePoint Sway document ensuring accurate reporting of reason for absence and identifying any additional support required				3. Process regularly reviewed and managers are trained and coached on the need to complete returns to work promptly			
4. Training for managers on all aspects of Managing Attendance – ensures focus is high and understanding of why this is important is maintained				4. Managing Attendance training register of attendees.			
5. Reporting to Board, CASC, PCC, ELT, SLT, SOT, Directors and managers on sickness data. Leadership reporting includes deep dives and analysis of data.				5. Appropriate reporting for assurance to a range of audiences with feedback and support for further action.			
6. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme- providing professional support				6. Managers have access to specialist advice and guidance from People and Culture team colleagues			
7. Suicide first aiders, TRIM, Peer Support Networks, coaching and mentoring framework in place giving additional layers of support, Health and Wellbeing Steering Group in place.				7. Reporting in place on numbers of suicide first aiders and demand for support. Reporting on access to TRIM and Wellbeing Service, including reporting themes and user experience feedback. Promotion of wellbeing support across WAST.			
8. Staff surveys- assess levels of engagement and wellbeing				8. Use of HIVE survey tool and insight data from the NHS Wales staff survey provides feedback on overall engagement and wellbeing			
9. Stress risk assessments- identify measures that can be taken to address issues				9. Reference to the assessments during attendance management line manager training and to the use of stress risk assessments promoted to managers			

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	15/10/2025	TREND	16 (4x4)
		Date of Next Review:	15/11/2025	➔	
10. External agencies support e.g., St John Ambulance, Fire and Rescue- if needed at times of increased demand pressure	10. SLA Agreements.				
11. Guidance for managers on alternative duties and monthly reviews of colleagues on Alternative duties	11. Action planning and timeboxed activities to support in a timely way.				
12. Sickness audits for localities- provides additional level of detail and additional support for areas with higher sickness levels to support work to reduce those levels	12. Delivery of audits and follow up actions				
13. <b>Support</b> by PS project lead with relevant PS team then supporting line managers and tracking actions on <b>longest absence cases</b>	13. Provides a focus on higher risk cases where more intense action or support may be required.				
14. Delivery of specific projects and pieces of work to support the reduction of sickness absence across the organisation.	14. Offers assurance to ELT on the activities and measures in place. Figures on absence are being reported monthly to ELT which is reflected in the minutes and AAA reports				
15. Work in Confidence system implemented and Guardian appointed to support colleagues coming forward with concerns and potentially reducing levels of stress and avoiding sickness absence.	15. External Management (2nd Line of Assurance) and Audit.				
16. Strengthen Speaking Up Safely Arrangements policy and advice and roll out of increased awareness of routes to speak up and raising concerns.	16. Monitor SUS concerns and they are dealt with in agreed timeframes and assessed whether absence related to mental health and anxiety reduces.				
17. Actions identified from the Managing Attendance Audit implemented	17. Agendas, minutes etc.				
18. PADR review undertaken and now including wellness questions	18. Underway and now BAU – ensures managers are talking about individuals' wellbeing and what additional support or signposting can be provided				
19. Specific interventions on all long-term sickness absence cases to ensure there is a tailored, individual action plan which identifies interventions that will support a return to work as soon as reasonably possible.	19. PADRs undertaken and questions asked; Discussion on levels of long-term sick absence is undertaken in a variety of forums including JCC, ELT and PCC.				
20. Accountability meetings on attendance management between People Services and senior ops managers to ensure this issue is given sufficient focus on priorities and ADs hold their senior teams accountable for their team figures	20. Meetings taking place and active on operational areas experiencing high levels of absence				
21. TU engagement on attendance issues e.g. muscular skeletal conditions is discussed regularly at the H&S Committee and relevant additional interventions are identified	21. Included on agendas and outcomes are available for discussion at H&SC.				
22. Wellbeing team have a referral pathway for mental ill health and are confident liaising with local services when necessary.	22. Regular reporting and the introduction of a user experience survey.				
23. Guidance and training available for line managers to equip them with the confidence and skills to have meaningful and sensitive conversations related to attendance.	23. Incorporated in Our WAST Way and measured through ongoing participation in development sessions				
24. Targeted culture change reviews are undertaken in areas of the business where levels of absence are high and other metrics such as turnover indicates concerns.	24. Culture review action plans are produced and taken forward. Sick absence in these areas is evaluated and monitored to assess whether reductions are achieved.				
25. Culture work on creating the sense of team and peer responsibility / ownership	25. Incorporated in Our WAST Way – Leadership at all levels and through the culture champions network, with focus on Our Best behaviours.				
26. Health Diagnostic Programme available for those over 46 to identify undiagnosed conditions	26. Launched and staff trained. Clinics to commence end June 2025.				
27. Reporting on All Wales OH KPIs	27. Reporting in place, additional reports alongside the All Wales OH KPIs.				
28. Men's Health Support	28. Links available within siren and via the wellbeing practitioners to support mental health				
29. Implementation of new approach to regularly checking in with staff. Piloting a simple conversation framework for Managers to use with their staff on a monthly basis which provides a focus on wellbeing, goals and personal development.	30. Part of Our WAST Way; all those with management responsibility are expected to complete the sessions.				
31. Areas of business where attendance management has improved significantly to share learning across WAST	30. Ongoing tool being utilised as BAU				
32. Connect to other Ambulance sector organisations to identify additional interventions they have implemented to address attendance management, share learning and consider whether to adopt in WAST	31. Continued discussions as part of our ongoing culture change.				
32. Review patterns of absence	35 Reported to ELT and PCC in Feb 25 on findings. Completed and now BAU				
<b>36 Development of a refreshed stress risk assessment is underway. This will be relaunched with managers when completed</b>	<b>Source of assurance to be identified</b>				

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	15/10/2025	TREND	16 (4x4)
		Date of Next Review:	15/11/2025	➔	
		<b>Independent Assurance (3<sup>rd</sup> Line of Assurance)</b>			
		1b. Internal Audits scheduled through Shared Services Partnership. Last audit on attendance was November 2022 and the last actions from this due at the end of December 2023. (last audit November)			
		2. Internal audit of Occupational Health and Wellbeing completed with reasonable assurance, completed March 2025			
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>			
(a) Consistency and Application in Managing Attendance at Work Policy		There are other factors that impact on sickness which are difficult to control as they are linked to system wide challenges			
		Absence data is not updated in a timely manner into ESR by managers			
Opportunities to improve education and communication with managers about resources available and how to implement it e.g., stress risk assessments		Further roll out and access to learning around sickness absence on process, supporting docs and on how to approach managing attendance			
<b>Actions to reduce risk score or address gaps in controls and assurances</b>		<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>	
1. Development of the 2024/25 Managing Attendance Plan (see below for individual actions.		Deputy Director of People	To commence 30/05/24	Key plan actions noted below	
2. Increase manager support on data interpretation and analysis		Deputy Director of People	31.09.2025 <b>revised date 31.03.26</b>	<b>Data analyst appointed in Workforce Planning team who will look at sickness data and reporting opportunities at a local level</b>	
3. Analyse link between hot spots and the culture in these areas to address cultural issues		AD for Culture, Inclusion & Wellbeing	31.03.2025 <b>revised date 31.12.2025</b>	111 and 999 sickness levels reviewed: link to repetitive roles, exposure to distressed patients. Additional management layers in CCC should start to show positive impact on attendance. Consideration to be given to whether change management approach being applied in these areas is having an impact. New date due to focus on launch of Our WAST Way by the team	
4. Identify opportunities to improve roles – flexibility, control, confidence		Deputy Director of People / ADs, Operations	31.09.2025	Work to be undertaken to review whether any correlation between approved flexible working requests and attendance rates. <b>Tracking of flexible working requests has seen an increase in requests and approvals, especially within operations.</b>	
5. Opportunities to adapt the work environment. Link to Risk 224 and Risk 558 regarding the risk with the impact on WAST colleagues of overruns as well as patients.		Deputy Director of People ADs, Operations Directorate colleagues	31.03.2025		
6. Review workloads and hours of work undertaken by colleagues. Including colleagues not on GRS.		Deputy Director of People /ADs, Operations	31.03.2025 <b>Revised date 31.12.25</b>	Yet to start due to other key projects and task and finish groups underway. <b>Also linked to overrun work.</b>	
7. Develop the team around the person model / individual support network		Deputy Director of People and Culture	31.03.2025 <b>Revised date 13.12.25</b>	Closer working with P&C team and managers on supporting colleagues who are off. Case reviews undertaken where appropriate Happening in the majority of LTS cases. Will ask Head of PS to pick up and tighten up arrangements / process	
8. Increase lifestyle advice and guidance		AD for Culture, Inclusion and Wellbeing	31.03.2025 <b>30 November 2025</b>	Occupational Health and Wellbeing Team developing expertise in specific areas; calendars of events; health promotion. 1 April 2025 – Plans in place but team capacity means postponed. 11 August 2025 – Health Diagnostics launched.	

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan		Date of Review:	08/10/2025	TREND	16 (4x4)
			Date of Next Review:	08/11/2025	➡	
IF there is a lack of resources and available technology and infrastructure	THEN there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	RESULTING IN negative environmental and social impacts causing reputational damage		Likelihood	Consequence	Score
			Inherent	5	4	20
			Current	4	4	16
			Target	2	4	8
IMTP Deliverable Numbers: 17, 18, 33						
Strategic Objective:						
EXECUTIVE OWNER		Executive Director of Finance and Corporate Resources	ASSURANCE COMMITTEE		Finance and Performance Committee	
<b>Risk Commentary</b>						
Challenges continue around resources and technology, and currently there is not an ability to reduce this score. Decarbonisation Programme Board continue to meet. Noting some progress on positive movement to actions within the DAP. Recent progress is focussing on implementation of PHEV and BEV SRVs. WG is refreshing the Strategic Delivery Plan – final version of the document not yet received						
<b>CONTROLS</b>			<b>ASSURANCES</b>			
			<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. Oversight of implementation and delivery of Decarbonisation project and monitoring of action plan at Decarbonisation Programme Board and Capital Management Board			1. Regular meetings of the Decarbonisation Programme Board quarterly. Requirements of the Decarbonisation project have been presented to the Trust Board & Finance and Performance Committee. Challenges of the project have also been highlighted. Report goes regularly to FPC and then onto Trust Board. Next update will be <b>January</b> FPC meeting			
2. Capital and Estates directorate lead support – Director of Finance (DOF)			2. Regular briefings to DOF			
3. Partnership working via Communications/Stakeholder liaison group with NHS Wales, Welsh Government and other bodies to gain support and knowledge- with the anticipation of working in collaboration.			3. Sharing of knowledge via partnership working through various forums is documented in minutes of meetings held. Requirements also form part of the action plan			
4. Approach changed for heating/lighting/energy systems to become more energy efficient- replacing old inefficient plant with more sustainable technology such as natural gas boilers for air source heat pumps			4. (i) Estate Survey undertaken every 5 years. This is a 6-facet survey to understand where the back log is and the requirements for energy systems. Next survey round to take place in 2025/26 which will inform the update of the Estates SOP. (ii) Approved Estates SOP (iii) Estate Retrofit Guide and framework used to prepare schemes			
5. Changing procurement practices for fleet, Estates, equipment, supplies, and ICT to reduce emissions			5. Fleet SOP shows move to ULEV vehicles. BJC 2025/26 details intention for move to EV for smaller and support vehicles. <b>Ambitions for further decarbonisation of fleet to be included in 2026/27 Business Justification Case (currently in development)</b>			
6. Board Development sessions with respect to Decarbonisation to raise awareness of decarbonisation requirements, additional sessions will be required.			6. Board Development session occurred on 8th November 2021 – presentation slides are available.			
7. Finance & Performance Committee has oversight of decarbonisation project, decarbonisation to become a standard agenda item.			7. (i) Routine updates at every other FPC meeting (3 times a year) (ii) Annual report (which includes a Sustainability section) is approved by the Finance & Performance Committee			
8. KPIs with respect to energy transmissions are communicated to Estates team annually by sustainability manager			8. KPIs to Estates team includes energy use at all WAST managed buildings			
9. ISO14001 accreditation in place			9. ISO14001 – Annual audits are undertaken against the accreditation. Environmental Coordinators act as champions in the organisation.			
10. Environment Strategy in place			10. Environment strategy has been approved by the Trust Board. This covers the next 5 years			
11. Programme Board Risk Register			11. Programme Risk Register reviewed at every Decarbonisation Programme Board meeting			
12. Reporting to WG via DCR reporting, qualitative, and quantitative reports and emissions reporting			12. Submissions to WG – quarterly DCR reporting. Annual qualitative and quantitative reporting			
13. Membership of National Programme Board (WG), Transport Task and Finish Group and BELP Project Board			13. Minutes and papers of meeting			
14. Full engagement in Strategic Development Plan (SDP) refresh process undertaken by Welsh Government			15. WAST specific comments provided. Full engagement in support of influencing future SDP (and therefore DAP) actions.			
			<b>External - Independent Assurance:</b>			
			<ul style="list-style-type: none"> <li>Sustainability section in Annual Report audited by Internal Audit. Annual audits by BSI on accreditation</li> </ul>			

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	08/10/2025	TREND	16 (4x4)
		Date of Next Review:	08/11/2025	➡	
GAPS IN CONTROLS		GAPS IN ASSURANCE			
1. Establishment of further workstreams to address a Programme Plan to support strategy requirements					
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles					
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited)					
4. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost.					
Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:		
1. Establishment of potential further workstreams to address a Programme Plan to support strategy requirements: Consider further workstreams required in support of delivering DAP actions, including grouping of similar actions	Capital Development and Estates Team	Not needed. Action closed. <b>Do these need to be removed?</b>	Workstreams were set up to manage delivery of the EFAB projects and the transport element (Transport Project Board). Links are also made into ongoing work to develop the IMTP and develop longer term strategies e.g. Fleet Vehicle Procurement Strategy 2025 – 30.		
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles: develop an investment strategy/prioritised list of sites where further EV charging is required. Will need further investment.	Decarbonisation Programme Board	Ongoing programme of investment. Next phase to be complete by March 2026	Actions taken in line with investment provided to implement rapid charging by end of March 2025 at a small number of sites. Confirmed adequate charging provision for the replacement of 20 x PHEV and 10 x BEV in March/April 2025. This action is ongoing. Further consideration of the increasing resource requirements will be highlighted at the Transport Project Board, Decarbonisation Programme Board and through the Capital Management Board. Specific action in relation to development of investment plan was closed on the Audit Tracker in March 2025, given that this has been absorbed within other strategic investment plans.		
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited): development of specifications for vehicles considering achievable and safe ULEV options where possible. NOTE: will be dependent on confirmation of 2024/25 BJC funding	Fleet Team	Ongoing programme of investment. Next phase to be completed by March 2026	Position remains that only vans can currently be purchased. This will be delivered by March/April 2025. Further PHEV SRVs and full BEV small NEPTS vehicles to be procured in 2025/26 for implementation by end March 2026.		
4. NED support ended April 2022: A new NED will need to be nominated to champion this risk/project at Trust Board level	Director of Corporate Governance / Board Secretary	Not being progressed <b>Do these need to be removed?</b>	To be further discussed with relevant Directors. It is unlikely that a NED Champion role will be allocated in the near future.		
5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost: Development of an investment requirements schedule (also aligned to IA recommendations). Contribute resources to support the Decarbonisation Strategy action plan	Director of Finance & Corporate Resources	31.03.25 March 2026	Discussions ongoing regarding enhanced resource requirements to implement low carbon emission vehicles. Targeted Estate Fund (TEF) bids were submitted, and it has been confirmed that 3 of the 6 submitted projects have been supported. Work is well underway on delivery of the 2025/26 schemes.		

Risk ID 671	Unauthorised or Inappropriate use of AI technologies		Date of Review:	07/10/2025	TREND	16 (4x4)
			Date of Next Review:	07/11/2025	➡	
<b>IF</b> staff use Gen-AI tools (e.g. ChatGPT, Copilot, Gemini) or other AI-enabled platforms (including standalone apps, algorithms or built-in functionality) outside of approved organisational channels or without appropriate governance	<b>THEN</b> information passed into, accessed by, or returned by the AI tools may breach information security and data protection controls, and use of the output may breach transparency, medical device, equality, Welsh Language and ethical requirements	<b>RESULTING IN</b> potential breach of confidentiality and data protection law, data leakage (staff, public and business sensitive information), damage to Trust reputation through such a breach or through FOI responses, and non-compliance with other EU, UK or Welsh legislation, regulation and standards		Likelihood	Consequence	Score
			Inherent	5	4	20
			Current	4	4	16
			Target	2	4	8
IMTP Deliverable Numbers:						
Strategic Objective: Being at the forefront of innovation and technology						
<b>EXECUTIVE OWNER</b>		Director of Digital	<b>ASSURANCE COMMITTEE</b>		Finance & Performance Committee	
<b>Risk Commentary</b>						
<p>The current risk is high due to the appetite of WAST to adopt new AI technologies, and the ease of access by individuals to a breadth of (freely) available Generative-AI tools offered by tech start-ups and companies globally, and the limited guidance and regulation offered in this sector for health &amp; care providers.</p> <p>Given the evolving nature of AI technologies, it will not be possible to fully mitigate this risk. The consequences will remain, but with greater awareness, confidence and support for staff, the chance of breach, bias, or reputation damage from AI output can be reduced.</p>						
<b>CONTROLS</b>			<b>ASSURANCES</b>			
1. Guidance & Awareness <ul style="list-style-type: none"> <li>a) Gen-AI guidance (issued to all WAST January 2025)</li> <li>b) Copilot guidance (issued to Copilot pilot cohort only)</li> <li>c) Engagement sessions (small audience)</li> </ul>			1. Guidance & Awareness <ul style="list-style-type: none"> <li>a) Copilot Pilot feedback form</li> </ul>			
2. Strategic Alignment <ul style="list-style-type: none"> <li>a) IMTP reference to use cases</li> </ul>			2. Strategic Alignment <ul style="list-style-type: none"> <li>a) AI safety and adoption updates reported via Digital Report to Finance &amp; Performance Committee bi-monthly</li> <li>b) IGSG maintain responsibility for data protection and information security, including in respect to AI. IGSG report via AAA to ELT monthly and an IG report passes to Finance &amp; Performance Committee bi-monthly.</li> </ul>			
3. Technical Controls <ul style="list-style-type: none"> <li>a) Digital issued and managed Copilot licences (and pilot)</li> <li>b) Deactivation of licences not regularly used</li> </ul>			3. Technical Controls <ul style="list-style-type: none"> <li>a) Monitoring of Copilot users via MS Purview</li> <li>b) Copilot pilot evaluation feedback allows scrutiny of use cases and applications at regular intervals</li> </ul>			
4. Processes <ul style="list-style-type: none"> <li>a) Cyber Assurance of suppliers during procurement processes through existing mechanisms e.g. cyber essentials</li> <li>b) Data Protection related to AI projects / tools covered by existing DPIA</li> <li>c) Alignment with NHS Wales guidance and position including e.g. procurement routes</li> </ul>			4. Processes <ul style="list-style-type: none"> <li>a) Cyber risks and Data Protection logs reported to IGSG.</li> <li>b) Monitoring of Datix incidents related to data breaches and security</li> </ul>			
5. Expertise <ul style="list-style-type: none"> <li>a) Ability to draw on Digital expertise for advice (including data science, algorithmic, cyber, data protection, data quality and other relevant domains)</li> <li>b) Leverage support from existing suppliers with technical expertise (e.g. Microsoft)</li> </ul>			5. Expertise <ul style="list-style-type: none"> <li>a) AI risks and issues informally reported via IGSG to date in lieu of dedicated forum</li> </ul>			
<b>GAPS IN CONTROLS</b>			<b>GAPS IN ASSURANCE</b>			
1. Guidance & Awareness <ul style="list-style-type: none"> <li>a) Copilot rollout and chat requires guidance for all WAST staff</li> <li>b) General awareness sessions / e-learning for all WAST staff</li> </ul>			1. Guidance & Awareness <ul style="list-style-type: none"> <li>a) eLearning compliance</li> </ul>			
2. Strategic Alignment			2. Strategic Alignment			

Risk ID 671	Unauthorised or Inappropriate use of AI technologies	Date of Review:	07/10/2025	TREND	16 (4x4)
		Date of Next Review:	07/11/2025	➔	
a) AI Mission Statement / strategy b) Clear set of 'approved' use cases c) Steering Group to maintain alignment of use cases and horizon scan (for opportunity and risk)	a) Regular reporting and clear governance route from AI Steering Group to Board				
3. Technical Controls a) MS 365 Copilot chat offer for all staff (without need for upgraded licence) - needs monitoring for appropriate use b) Sanctioned / unsanctioned apps list to be maintained c) Monitoring and auditing of users d) Sensitivity tagging project for all digital documents to support access management e) Metadata / data quality project to support accurate AI use	3. Technical Controls a) Escalation route established for inappropriate use of Copilot chat and other available tooling b) SharePoint access and controls to be tested and confirmed				
4. Processes a) Procurement to consider AI specific requirements b) IG x AI Programme to be developed c) WAST AI Policy to consider UK and Welsh position across several domains (data protection, cyber security, WBFGA, Equality Act, Welsh Language etc)	4. Processes a) Processes to be identified, developed and maintained by AI steering group				
5. Expertise a) AI lead to be determined and position filled b) AI Steering Group to advise and guide on AI-related decisions and progress c) Connection in with NHS Wales and public sector specialist groups.	5. Expertise a) DTIP forum in development to support governance routes and in decisions related to capacity, planning and prioritisation of Digital expertise to WAST projects b) AI Steering group AAAs reported through correct governance routes				
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:	
1. Publication of WAST AI Policy	Leanne Smith	November 2025	AI Policy in development with support from TU Partner		
2. Agreement on sanctioned and unsanctioned apps, and block of certain apps / sites	James Rowland	Q4 25/26	WAST to align with national steer on sanctioned / unsanctioned apps		
3. AI Steering group (AISG) to be established	Leanne Smith	October 2025	To report to IGSG		
4. Awareness campaign (including ethics, DP, shadow IT risks)	Leanne Smith	Q1 26/27	To be managed by AISG		
5. Board Development Day and AI Mission Statement development with Trust Board	Leanne Smith	February 2026			
6. Copilot rollout to avoid ChatGPT risk – requires usage monitoring mechanism	Aasha Cowey	June 2026 (current pilot licences run until this time)	Dependent on funding		
7. Alignment with WG and NHS Wales AI policy positions	Leanne Smith	Q4 25/26	Proactively engage with WG AI Commission		
8. eLearning for all staff	Kara Walsh	Q4 25/26	Supported by AISG		
9. IG x AI programme (confirming DPIA and checklists are appropriate)	Kelly Holding	Q4 25/26	Will be a requirement of the 26/27 IG Toolkit		
10. WG AI Commission membership / alignment	Leanne Smith	Q3 25/26	Proactively engage with WG and NHSW AI groups		
11. Document sensitivity / confidentiality tagging project (linked to SharePoint migration project)	Leanne Smith / Aled Williams	Q4 26/27	Large scale project across digital		
12. AI Lead to be identified and agreed	Leanne Smith	Q3 25/26	AISG to have oversight		
13. Monitor usage	Kara Walsh	Ongoing from Q3 25/26	AISG to have oversight		

<b>Risk ID</b> 558	<b>Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences</b>		<b>Date of Review:</b>	15/10/2025	<b>TREND</b>	15 (3x5)
			<b>Date of Next Review:</b>	15/11/2025		
<b>IF</b> significant internal and external system pressures continue	<b>THEN</b> there is a risk of a significant deterioration in staff health and wellbeing within WAST	<b>RESULTING IN</b> increased sickness levels, staff burnout, poor staff and patient experience and patient harm		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
			<b>Inherent</b>	4	5	20
			<b>Current</b>	3	5	15
			<b>Target</b>	2	5	10
IMTP Deliverable Numbers: 13, 14, 21, 26						
Strategic Objective:						
<b>EXECUTIVE OWNER</b>		Director of People	<b>ASSURANCE COMMITTEE</b>		People & Culture Committee	
<b>Risk Commentary</b>						
<p>This risk should be considered alongside Risk 160 as the resulting increased sickness levels mentioned above will be addressed by the same controls and assurances. The ongoing system pressures including long handover delays, overruns and missed breaks continues to remain a challenge to mitigate this risk. WAST continues to work in partnership with the system to pilot viable options for addressing the external factors. Although there has been some success in some areas, we are yet to see these being scaled to an extent that the employee experience has been impacted. Since 2020 we have not seen the previous pattern of easing over the summer months and with the current public health risk of measles and continuing risks of covid this risk remains static. The People and Culture Plan 2023-2026 is a good summary of the controls and actions addressing this risk. Work on reducing shift overruns continues with various pilots being run to test viable options which could be implemented. Proposed increase in score as a result of system pressures. Whilst we are seeking to address this, and it will take time to have an impact. Adding in the potential future financial pressures (leaving vacant posts open for longer), will further exacerbate this issue.</p>						
<b>CONTROLS</b>			<b>ASSURANCES</b>			
			<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
13. The new Health and Wellbeing Plan 2025-2029 has now been drafted and is out for consultation. The aim of the new plan is to expand on consideration of employee experience to recognise that individual wellbeing interventions are not sufficient in mitigating system wide pressures.			13. New Health and Wellbeing Plan 2025-2029 is aligned closely to People and Culture Plan and delivery monitored via the Health and Wellbeing Steering Group, reporting into the People and Culture Business Meetings. This plan was created in line with the HEIW Best Practice Guide for Organisations			
14. Occupational Health & Wellbeing team with range of support options for individual mental health intervention signposting, MSK support, reasonable accommodations and recommendations, supported by mental and physical health expert clinicians.			16. Current waiting times are just above the national SLA of 29 days, at 31 days. , External providers meet quarterly and provide monthly engagement figures. Reporting into OHW operational team meeting and MIQPR.			
15. Wellbeing Service providing training, consultation and advice to line managers supporting members of staff with severe and complex health and wellbeing challenges. Including REACT training that supports managers with difficult conversations.			17. Rolling programme of workshops, attendance at team events when requested, evaluation and numbers trained reported at OHW operational meetings. Diarised meetings, webinars and workshops in place through a rolling programme. These offers are now evaluated via user experience questionnaires which are reported to the health and wellbeing steering group. Wellbeing training uptake numbers is reported into the OHW Operational Team Meetings.			
16. TRiM (Trauma Risk Management Network) in place to support staff following exposure to potential traumatic events and materials. The approach of watchful waiting by a clinician or peer supporter means we can support those who have been exposed to such events and escalate to support if required.			18. TRiM is facilitated by the Wellbeing Service Assistant Psychologists supervised by a Clinical Psychologist to provide appropriate professional oversight. Numbers of referrals, assessments, follow-ups and further support needs are reported to the Health and Wellbeing Steering Group			
17. Acting on results of staff surveys relating to staff experience, data triangulated with pulse surveys and other cultural metrics as detailed in the People and Culture Plan.			19. Each Directorate has developed their own action plan to address staff surveys. NHS staff survey high level results released 19/02/24 with directorate specific data released in April 2024. The survey was repeated in Autumn 2024, and we are awaiting the next set of results.			
18. HSE stress risk assessments			20. Undertaken by managers and advice is provided on how to use them by Occupational Health and Health and Safety teams.			
19. KPIs are reported fortnightly regarding Occupational Health and Wellbeing activity			21. Received at OHW operational team meeting and reported in MIQPR.			
20. Wellbeing drop-in sessions for CCC and 111 staff			22. These sessions are now part of business as usual across services and a user experience form is collating more formal quantitative feedback for OHW operational team meetings. Data to date has been qualitative and the quantitative has been measured by engagement with the service. Themes of staff concerns are also collated by wellbeing staff attending WAST sites.			
21. Fast track physiotherapy to address MSK issues.			23. Regular review meetings with physiotherapy provider and monthly monitoring information received at People and Culture Business meetings and MIQPR			
22. Occupational Health team inclusion in sickness and absence meetings			24. Qualitative anecdotal feedback has been positive, and it has strengthened relationships with the OH team. More formal feedback mechanisms are in development in line with our overhaul of service feedback.			
23. Stress risk assessments			25. These are part of the IOSH Managing Safely Training.			
			<b>External - Independent Assurance</b> - Audit Wales – Taking Care of the Carers report in October 2021 – all actions complete			

<b>Risk ID</b> 558	<b>Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences</b>	<b>Date of Review:</b>	15/10/2025	<b>TREND</b>	15 (3x5)
		<b>Date of Next Review:</b>	15/11/2025		
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>			
11. Need to increase the education and communication with managers about stress risk assessments. Presentation developed and shared with people services. Delivery dates being agreed in conjunction with Health and Safety, along with a new policy. These discussions have restarted, and colleagues are directed to the stress risk assessment information and education sessions will be started in Q1 & Q2.		Lack of awareness about staff wellbeing services, this continues to be a challenge due to small team, non-wired colleagues and competing communication messages.			
		Effects of elevated REAP status affecting the ability of staff to engage with staff health and wellbeing services. Important to recognise the consistent reports of the impact of culture on wellbeing. Attendance at all events by operational staff consistently low due to service pressures.			
<b>Actions to reduce risk score or address gaps in controls and assurances</b>		<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>	
1. People and Culture Plan 2023-2026 relevant Actions		Assistant Director for Inclusion, culture and wellbeing	Annual Plan December 2026	First year reviewed at People and Culture Committee May 2024 23/7/24 Final year review included in consultation process for new plan	
2. Health and Wellbeing Plan 2025-2029		Assistant Director for Inclusion, Culture and Wellbeing	Approved by Board Q3 2024/25 2025/2026	Plan has been approved by Board. The delivery period begins 2025/2026. Promotion of the plan and key deliverables will commence then. 2 June 2025 Plan being delivered and overseen by the Health and Wellbeing Steering Group which meets quarterly.	

<b>RISK ID</b> 594	<b>The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death</b>	<b>Date of Review:</b>	01/10/2025	<b>TREND</b>	15 (3x5)	
		<b>Date of Next Review:</b>	01/11/2025	➔		
<b>IF</b> a major incident or mass casualty incident is declared	<b>THEN</b> there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	<b>RESULTING IN</b> catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
			<b>Inherent</b>	4	5	20
			<b>Current</b>	3	5	15
			<b>Target</b>	2	5	10
IMTP Deliverable Numbers: 1, 5, 6, 7,14, 15, 24						
Strategic Objective:						
<b>EXECUTIVE OWNER</b>	Director of Operations	<b>ASSURANCE COMMITTEE</b>	Finance & Performance Committee			
<b>Risk Commentary Q1 2024/2025</b>						
<p>The challenges across the unscheduled care system. Handover lost hours in <b>August</b> were <b>13,135</b> and <b>September</b> were <b>12,189</b>. There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital E.Ds. Several incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.</p> <p>After a thorough review and assessment of Risk 594 within the Corporate Risk Register at SLT on 02/10/2024, we propose reducing the risk score from 20 to 15 (likelihood from 4 to 3) due to the following reasons:</p> <ul style="list-style-type: none"> <li>· Mitigation/Controls have been Implemented: We have several controls measures that directly address the identified risk and are content we have exhausted all opportunities for additional controls. These controls are embedded within the corporate risk register.</li> <li>· Immediate Release Protocol: The revised version of the IR protocol v1.3 has been agreed and shared at COO group and published which has included the release schedule for ambulances at the declaration of an incident as set out below: <ul style="list-style-type: none"> <li>·50% of vehicles released within 10 minutes</li> <li>· 75% of vehicles released within 20 minutes</li> <li>· 100% of vehicles released within 30 minutes</li> </ul> </li> <li>· Monitoring and Review: We will continue to monitor the risk within the normal governance channels (SOT/SLT/ADLT etc) to ensure that mitigations are still in place and any emerging risks are promptly identified and addressed.</li> </ul> <p>22/01/25 - In light of the critical incident declared earlier this month, a review of the risk scoring is scheduled for this at SLT on 11<sup>th</sup> February in the first instance and this will be updated following conversations.</p> <p>March 25 – following review at SLT, it has been agreed to maintain the score as it stands currently.</p>						
<b>CONTROLS</b>			<b>ASSURANCES</b>			
			<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. Immediate release protocol			1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Dated by WAST and compliance report provided weekly to the DG for Health & Social Services. V1.3 has been reviewed, updated and released (August 2024).			
2. Resource Escalation Action Plan (REAP)			2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v5.1 released in January 2025			
3. Regional Escalation Protocol			3. Daily conference calls to agree RES levels in conjunction with Health Boards			
4. Incident Response Plan			4. The Incident Response Plan has been ratified via EMT			
5. Mutual Aid arrangement with NARU			5. AACE National Policy on mutual aid in place			
6. Clinical Safety Plan			6. CSP adopted by EMT and operational; reviewed annually by SLT in December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU. New version 3.3 released in December 2024.			
7. Operational Delivery Unit 24/7 cover			7. Shift reports from ODU & ODU Dashboard received by Exec, SOT, and On-Call Team at start/end of shift and cover review at weekly performance meeting			
8. In hours and Out of hours command cover			8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan. Cover review at weekly performance meetings			
9. Notification and Escalation Procedure			9. Published procedure in operation, reviewed 3 yearly by SLT			
10. Continued escalation of risk to partners and stakeholders			10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasised at the face-to-face COO Peer Group meeting on 14 April 2023.			

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death		Date of Review:	01/10/2025	TREND	15 (3x5)
			Date of Next Review:	01/11/2025		
		<b>External Independent Assurance</b> N/A				
11. CEO letter to Health Boards dated 3 Jan 2023, and DOO letter to Chief Operating Officers dated 30 March 2023 to seek assurance on plans.		11. Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of improvement with no delays more than 2 hours. Programme of improvement underway in ABUHB commencing at 4-hour tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.				
12. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration.		12. All Health Boards responded with assurance of plans except BCU.				
13. Multi Agency Exercise to be arranged.		13. This exercise has taken place although Health Boards declined to incorporate vehicle release plans				
14. Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.		14. WG have confirmed that they have written to HB EPRR leads. Health Board COOs approved the proposals for vehicle release as outlined.				
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>				
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.		The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.				
		Following two incidents (Pembroke Dock Ferry fire on 11 <sup>th</sup> February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morryston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).				
<b>Actions to reduce risk score or address gaps in controls and assurances</b>		<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>		
1. Review of Manchester Arena Inquiry		Assistant Director of Operations	<b>CLOSED</b>	This programme of work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios. The financial case associated with MAI is planned to be familiarised with ELT and JCC during Jan and Feb 2024, with the final outline case to ELT in March 2024. A revised timeline for the governance process for the final MAI reports has been agreed, commencing in May 2024 and finalising at Trust Board the end of July 2024. 01/10/2024 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust continues. The Trust has undertaken a detailed review of its provision as part of its obligation under recommendations 105 and 106 and has recently produced an evidence-based series of reports aimed at addressing the identified gaps. This has been supported further by the development of three Quality Impact Assessments that have been approved by the Clinical Quality Governance Group. The work identified 20 recommendations for which there is a financial dependency. The submission to commissioners of the Trust's reports relating to these recommendations has now occurred and the Trust awaits their considered response. The remaining recommendations continue to be progressed, and it is anticipated these will conclude within the next six months. To ensure the continued visibility of these report findings within the Trust, a corporate risk is being developed for inclusion in the Trust's risk register. This will enable the alignment of outstanding MAI recommendations with a clearly defined business-as-usual framework, ensuring proper governance of capability gaps while awaiting financial decisions from commissioners and the implementation of necessary changes.		

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death		Date of Review:	01/10/2025	TREND	15 (3x5)
			Date of Next Review:	01/11/2025	➔	
			<p>Jan 2025 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust, continues. We expect to complete all recommendations that do not rely on financial investment by the end of this financial year. To ensure the continued progression and completion of the recommendations with financial dependency (18 recommendations), a corporate risk has been developed for inclusion in the Trust's Corporate Risk Register and Board Assurance Framework. As the risk progresses through the internal governance route, culminating in final approval at Trust Board in January 2025, there is an alignment of the outstanding MAI recommendations with a clearly defined business-as-usual framework, which will support the governance of capability gaps whilst awaiting financial decisions from commissioners and the implementation of necessary changes.</p> <p>Mar25 – Progress of MAI will now be reviewed within CRR 641. During March and April the Trust has engaged with commissioners on a series of scrutiny sessions to review content of submission for the MAI, following these scrutiny sessions it will be the commissioners to determine next steps and any subsequent course of action.</p> <p>May 25 – Actions complete subject to closure report to SLT with outstanding actions monitored through the risk register (Ref: 641). Submission to commissioners completed and awaiting commissioner outcome expected August 2025.</p>			
2. Further correspondence to Welsh Government to seek assurance of testing plans following recent mass casualty exercise where Health Boards declined to incorporate vehicle release plans	Assistant Director of Operations	<b>CLOSED</b>	<p>Immediate Release Protocol Developed and Released August 2024. Correspondence with Welsh Government remains ongoing.</p> <p>22/02/2024 - Risk 594 has also been referenced in the context of MAI presentation to Welsh Government (6<sup>th</sup> Feb 2024). Further follow up will be provided as MAI progresses. Welsh Government has been and will continue to be kept up to date on the developing case, as have the JCC.</p> <p>May25 – Further correspondence submitted to the NHS Executive dated 28 April 2025, highlights that plans remain untested in the context of a continued deterioration on handover delays.</p>			
3. Request from COO network to share Action cards related to risk	Executive Director of Operations	<b>Q1 CLOSED</b>	<p>May24 – LB will follow up with COO network on the sharing of their action cards to WAST.</p> <p>March 24 – This risk was discussed at both JCC management and in the COO meeting.</p> <p>May25 – The Trust has now exhausted its influence on this risk, and with further correspondence to NHS Executive in April 2025 highlighting the outstanding risk and untested plans, the Trust considers all actions closed.</p>			

<b>Risk ID</b> 623	<b>Failure to comply with Data Protection Legislation</b>		<b>Date of Review:</b>	26/09/2025		<b>TREND</b>	15 (3x5)
			<b>Date of Next Review:</b>	25/10/2025			
<b>IF</b> the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	<b>THEN</b> the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	<b>RESULTING IN</b> unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>	
			<b>Inherent</b>	4	5	20	
			<b>Current</b>	3	5	15	
			<b>Target</b>	2	5	10	
IMTP Deliverable Numbers: 1, 13, 14, 18, 19							
Strategic Objective:							
<b>EXECUTIVE OWNER</b>		Director of Digital Services	<b>ASSURANCE COMMITTEE</b>		Finance & Performance Committee		
<b>Risk Commentary</b>							
<p>The consequences of this risk depend on the worst-case scenario which crosses a number of Domains on the Risk Scoring Matrix e.g. Loss of, or access to mass clinical data, the reputational damage this would cause, subsequent high-level involvement of ICO, Regulatory Body and Government involvement the subsequent fall out, fines and reduction in the level of clinical care. The likelihood would be small NB Just like pandemics. However, there are lower consequences of failure of statutory compliance which would warrant a higher level of likelihood even daily but in this case like near misses they indicate the need for change/improvement to demonstrate managing the risks. Therefore, the consequences will always be 5 but improvements are needed to lower the risk; if we demonstrate Statutory Requirements are met, even if a serious incident/event/failure arises, evidence provided would <b>help</b> reduce / mitigate against the consequences (<b>e.g. penalty</b>).</p> <p>In March 2025 the Trust submitted a self-assessment under the Welsh IG Toolkit, and met or exceeded expectations in all areas, except for the Training &amp; Awareness category (for which minimum expectations were not met.) <b>Last m</b> measured on the <b>23/09/25</b>, WAST had achieved <b>90.73%</b> compliance against an 85% target for statutory IG training. The Confidentiality Advisory Group (CAG), an independent body advising the UK's Health Research Authority on the use of confidential patient information in research projects, and the Secretary of State for Health for non-research uses, require organisations across NHS Wales to demonstrate compliance with legislation via the IG Toolkit, or risk requests for using sensitive patient information being rejected – this compliance achievement helps protects WAST's academic partnerships and reputation, strategic research endeavours, and patient data linkage initiatives should CAG support be pursued, but must now be maintained until the Toolkit is submitted in March 2026. <b>This is in addition to now meeting a new category of compliance covering video surveillance.</b></p> <p>If the Trust fails to meet the Minimum Expectations of the IG Toolkit, this highlights that the organisation may not be meeting its obligations under the accountability principle. The accountability principle places a responsibility on organisations to not only comply with the UK GDPR, but that they must also to be able to demonstrate compliance. If an organisation cannot show good data protection practices, it may leave them open to administrative fines (irrespective of a data breach), reputational damage and affect patients' trust in the organisation handling their data.</p> <p>Recently, several projects have seen delays due to outstanding IG queries, late engagement with the IG team, and project scope change impacting data protection. These have been escalated and are being managed but demonstrate some risk still in the understanding and awareness of IG and data protection requirements and responsibilities of staff, despite the increase in training compliance. Several <b>data breaches</b> remain under investigation, and there has been an increase in inappropriate use of social media <b>and non-corporate communication channels (e.g. Whatsapp).</b></p>							
<b>CONTROLS</b>				<b>ASSURANCES</b>			
				<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. Expertise: Data Protection Expertise: 2 x FTE Data Protection and Compliance Managers (DPCM); 1 FTE Information Governance Officer, 4 x FTE in the Cyber Security team				1. Two new permanent Data Protection and Compliance Managers have been in post since November 2024, bringing capacity of this skillset up to 3 x FTE.			
2. Expertise: Permanent Data Protection Officer				2. Temporary Data Protection Officer responsibilities held by Head of ICT up to December 2024. A full-time, permanent DPO has been recruited, and the position has been filled since December 2024.			
3. Documentation: Data Protection and Information Governance Policies and Procedures (Incl. DPIAs and Cloud Assessments)				3. Procedure for auditing Welsh Clinical Portal usage (by WAST staff) updated (Jun24). Monthly Information Governance Steering Group which includes progress updates on: - DPC, DSA and DPIA reviews (I) IG Training IG Toolkit (System for providing a level of assurance of compliance (I) Incident Reporting Accountability to ELT Development of reporting (dashboard) which supports IGSG, ELT and Finance & Performance Board Committee for scrutiny.			

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	26/09/2025	TREND	15 (3x5)
		Date of Next Review:	25/10/2025		
4. Documentation: Contracts and agreements: Data processing, Data Sharing and Employment & Consultancy	4. Add: Template Model Data Processor Agreements and Data Sharing Agreements which are able to be produced when IG are engaged.				
5. Ownership: Register of information assets and data flows (outdated)	5. <b>New Information Asset Management Group in process of being established with TOR developed.</b>				
6. Awareness: Staff training on updated training module (Apr 2023)	6. Training compliance monitored monthly via IGSG (captured on ESR and LMS365)				
7. Monitoring: Incident Reporting and management (DATIX)	7. Summary statistics reported monthly via IGSG and MIQPR				
8. Monitoring: NIIAS (national intelligent integrated audit solution) for auditing access to personal information on national systems such as WCP and WDS.	8.				
9. Awareness: Digital Notices / comms Ongoing (see Siren & recent Lock-screen notices)	9. Regular publication of IG related comms: Lock screen image issued 04/24 in relation to WhatsApp and training_Lock screen image in relation to physical security as ongoing recurring screen. Digital Notice on Whatsapp issued 04/25. AI Guidance issued 01/25. Cyber & IG procurement guidance drafted and available on SharePoint and shared to ADLT. Information Governance Factsheet produced and shared to new users of WCP, WDS, and Secure File Share Portal (and as and when needed to other groups). Presentations on Data Breaches and DPIAs are provided to groups.				
10. Collaboration: Proactive engagement outbound (not inbound to team)	10a. Regular comms issued across WAST in Q3 and Q4 of 2024/25, explaining the importance and encouraging uptake of IG Training – this included targeted messages to non-compliant individuals, and their line managers, and escalations to Executive level as required. 10b. Requests made for IG representatives to sit on project boards of critical workstreams and other Directorate forums, helping improve understanding, and collaboration, reducing risk of non-compliant go-lives or deliverables. <b>Delivery of training and awareness on 'Information Governance &amp; Transformation: What You Need to Know' to the Transformation Support Office.</b>				
11. Compliance: Trust meeting mandatory IG training compliance threshold of 85%	11. The Trust has seen increasing compliance for the past several months – this must now be maintained				
12. Ownership: documented risk for physical security with mitigating action plan	12. This risk was approved by IGSG in June 2025 and will now pass through usual Trust risk management cycles.				
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>			
1. Succession Planning and appropriate capacity within the team to manage the incoming demand from across the Trust and wider NHS Wales system (particularly in respect to national data sharing)	1. <b>Additional investment sought for IG team to bolster capacity, and ensure career progression through the specialist team (tbc in October 25).</b>				
2. Documentation: Resource capacity constraints to update, implement or monitor the controls; and lack of engagement by management and staff which either bypass the requirements, policies or procedures.	2. <b>Expertise: Even with increased capacity without engagement by managers and staff to meet their compliance requirements there will continue to be information reported to IGSG which will demonstrate low levels of assurance i.e. Reports on DPIA log, DSA log, Training Levels, IG Toolkit, and Implementation Plan</b>				
3. Documentation: Personal identifiable information (PII) is being processed or shared with no data processing contracts (DPC) or data sharing agreements (DSA) when legally required; or incomplete DPC or DSA due to stalled engagement.	3. <b>Documentation: Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could engage third parties and/or purchase IT systems, hire document scanning companies, external data consultants and analytical firms and bypass WAST's controls for appropriate due diligence or legislative required controls in managing these risks. Capacity constraints continue to impact ability to undertake audits of systems and access, timely completion of DPIAs, data breach management, and data flow mapping (Records of Processing Activity documentation.)</b>				
4. Ownership: New data, or new data processes which have either bypassed the controls or there are no information asset owners identified and therefore asset doesn't get on to the asset register or the dataflow is not mapped and creates a weakness in assurance (See 3)	4. Ownership: Data Protection and Compliance Risks not fully realised. IGSG have approved the establishment of a sub-group to manage activities related to Information Asset Register and Ownership, however, due to vacancies and limited capacity in the IG team, this action will not be able to be progressed until January-25.				
6. Documentation & Awareness: Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase non-compliant IT systems.					
7. Awareness: The Confidentiality Advisory Group (CAG) notified WAST (via DHCW) in June 24 that for organisations with a 23-24 IG Toolkit outcome of "standards not met", any CAG approvals for research & non-research requests are likely to be rejected unless the organisations' IG Toolkit Improvement Action Plan can be met and evidenced by Nov 24 (instead of the original target date for this plan of Mar 25).	7. Awareness: The Confidentiality Advisory Group (CAG) required WAST to submit an IG Toolkit Improvement Action Plan (via DHCW) with adjusted timelines to show a path to a "minimum standards met" position by Nov 24. The Improvement Action Plan has been adjusted and shared, and internal stakeholders notified. This will be managed by ADLT and monitored via IGSG. The Improvement Plan Actions were met by the Nov 24 deadline, satisfying the requirements of the CAG up to March 2025. However, with the IG Toolkit submission in March-25 this view will be reset, and WAST failed to meet the minimum expectations for Training and Awareness.				
<b>Actions to reduce risk score or address gaps in controls and assurances</b>	<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>		

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	26/09/2025	TREND	15 (3x5)
		Date of Next Review:	25/10/2025		
<p>1. Ensure compliance with the appropriate IG level training across all Directorate and Departments</p> <ul style="list-style-type: none"> <li>a. Demonstrate a regular series of comms on IG and DP - complete</li> <li>b. Regular monitoring of training compliance through IGSG – evidence of ongoing</li> <li>c. Targeted training compliance reporting to line manager on individuals to ensure that 85% target is reached by March 2025. - achieved in July 2025. This must now be maintained and will be monitored for the next few months to ensure progress does not slip.</li> <li>d. BAU on Siren training notices and specific guidance or advice – evidence of ongoing</li> <li>e. IG checklist to be complete for all projects, and DPIAs ahead of project design / development, and critically all go-lives to have IG approval</li> </ul>	Leanne Smith	<p>Q4 2024/25 Q2 2025/26</p> <p><b>Ongoing monitoring of Trust-wide compliance (will need to be demonstrated by March 2026) and current escalations for non-compliant individuals.</b></p> <p><b>Q3 2025/26</b></p>	<p>IG training compliance required to meet 85% target. An Action Plan for training has been created, and a training needs analysis being progressed with L&amp;D team.</p> <p>3d. Procedures, such as audit of Welsh Clinical Portal usage, has been updated.</p> <p>Previous actions: April 2024 - Lock screen issued in relation to WhatsApp and training, refreshed 06/24. May 2024 - Siren notice drafted for ELT. Jan 2025 - AI guidance issued. Mar 2025 - Cyber &amp; IG procurement guidance in development. Evidence that regular comms is being published, and so action complete, and assurances added to Controls. May 2025 - Ongoing comms on the importance of early engagement with IG to ensure legal required documents and risk assessment are completed will continue to be raised across forums.</p> <p>Jun 2024 - Paper to ADLT seeking support for increased awareness &amp; training compliance</p> <p>Mar 2025 - Direct contact to individuals who have been non-compliant for a significant period of time, with escalation through their line management structures as required.</p> <p>Latest actions: July 2025 - Letters have been issued to individuals and training is requested to be completed by end of August 2025.</p> <p>Several potential data breach incidents remain under investigation, and there has been an increase in inappropriate use of social media by staff – further work is required to give confidence in Trust compliance beyond threshold met.</p> <p><b>September 2025 – reduction from 290 to 194 staff with overdue mandatory training. IGSG continue to offer oversight and a route for escalation of non-compliance, with support given to further investigate staff with a professional registration who are out of compliance.</b></p>		
<p>2. Report on physical security to IGSG – working with fleet and estates team</p>	Leanne Smith and Aled Williams	<p>Q2 2024/25 Q1 2025/26</p> <p><b>Complete</b></p>	<p>Reporting to IGSG and FPC. A risk has been drafted by members of IGSG, and agreed, but action plan now to be developed in collaboration with Fleet &amp; Estates.</p> <p><b>The draft risk was approved by IGSG in July 2025 and will now progress through risk management cycles.</b></p>		
<p>3. Assurance of “standards met” for all IG Toolkit requirements: gain support of all Directorates’ leadership to complete the IG Toolkit Improvement Action Plan and ensure compliance for the <b>2025/26</b> IG Toolkit submission</p>	Leanne Smith	<p>Nov24 for IG Toolkit Improvement Action Plan (with evidence to CAG) - <b>complete</b></p> <p>March 2025 for 24/25 submission <b>complete</b></p> <p>March 2026 for 25/26 submission – <b>ahead of plan</b></p>	<p>Paper to ADLT Jun24 seeking support for completion of the IG Toolkit improvement action plan.</p> <p>To ensure no impact to CAG approvals for WAST research, this improvement action plan must now be met and evidenced by Nov24.</p> <p>The improvement plan actions resulting from the “standards not met” results of the 23/24 IG Toolkit submission were met ahead of the Nov24 deadline to assure CAG, however, to meet the requirements of the 24/25 IG Toolkit submission, further improvement work was required before the Mar25 deadline.</p> <p>All other improvement work was complete, and the submission of the IG Toolkit in March 2025 saw standards either met or exceeded in all categories except for Training &amp; Awareness, where standards were not met due to the IG Training compliance being below the 85% target.</p> <p>Progress on the 2025/26 improvement plan, to support the IG Toolkit submission in March 2026 is approximately <b>78</b> complete.</p>		

<b>Risk ID</b> 100	<b>Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience</b>		<b>Date of Review:</b>	19/08/2025	<b>TREND</b>	12 (3x4)
			<b>Date of Next Review:</b>	14/11/2025		
IF WAST fails to persuade JCC/Health Boards about WAST ambitions	<b>THEN</b> there is a risk of a delay or failure to receive funding and support	<b>RESULTING IN</b> a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
			<b>Inherent</b>	4	4	16
			<b>Current</b>	3	4	12
			<b>Target</b>	2	4	8
IMTP Deliverable Numbers: 7, 9, 11, 12, 14, 15, 20, 24, 25, 32						
Strategic Objective:						
<b>EXECUTIVE OWNER</b>	Executive Director of Strategy, Planning & Performance	<b>ASSURANCE COMMITTEE</b>	Finance and Performance Committee			
<b>Risk Commentary</b>						
<p>From the 01 April 2024 111, emergency ambulance and Ambulance Care are all commissioned by the Joint Commissioning Committee (JCC). This is viewed as a positive development by the Trust, supporting the development of an organisational ambition.</p> <p>The ambition is appropriate levels of patient safety and good working conditions for our staff across the 111 pathway, emergency ambulance care pathway and Ambulance Care pathway. Clearly neither of these are currently being achieved in the emergency ambulance care pathway as evidenced by the long waits, shift overruns and volume of concerns and reportable incidents. The Trust is currently commissioned on the assumption of 6,000 hours of handover lost hours, with current levels at 12,560 (Jul-25). The extant WG policy is 15 minute handover i.e. no lost hours, with the current WG focus on W45 i.e. 45 minute handover, which equates to approximately 6,000 hours. There is evidence of some material handover lost reduction in some health boards in recent months. The Trust had almost recruited up to the modelled 153 CHARU FTEs and connected to this focus on CHARU productivity. CHARU UHP in January 2025 was 94%, which is the highest it has achieved, and it is now seeking to close the remaining gap through the recruitment of fully qualified paramedics (current levels are staff in post to establishment for CHARUs at 85%). The Trust delivered on its ambition to switch on key aspects of its clinical model transformation programme in 2024/25, in particular, rapid clinical screening, which included the recruitment of 28 FTES to EMSC (clinical navigators) and increasing the APP establishment to APPs. The 111-call abandonment rate has stabilised post 111 CAS go live, as the Trust has recovered its call handler staff in post to establishment, but the commissioned levels are not sufficient to achieve the 5% abandonment rate. Ambulance Care performance is stable, but the level of capacity management plan cancellations are running at c20,000 per annum. For 2025/26 the Trust's ambitions are set out in its IMTP, with a particular focus on delivering further aspects of the clinical model transformation programme: the re-categorisation of 999 demand (purple, red and RCS0 etc), remote clinical care and further see &amp; treat capability. The EA skills mix (no funding from JCC) and Manchester Area Inquiry (MIA) submission are also important considerations.</p> <p>The JCC is now becoming more established. Current areas of focus for the JCC (in relation to WAST) include: a scrutiny exercise on the Trust's MAI submission, consideration of the Future Vision for NEPTS, the Emergency Ambulance Measures Review Task Group and Ambulance Patient Handover Improvement Implementation (APHID) Group. The Trust has received the JCC commissioning intentions 25/26 for 111, 999 and NEPTS, which are reflected in the Trust's IMTP. These are broadly supportive of the Trust's ambitions, but the financial pressures within NHS Wales means that there's limited financial support of the Trust's ambitions.</p>						
<b>CONTROLS</b>			<b>ASSURANCES</b>			
			<b>Internal &amp; External Management (1<sup>st</sup> Line of Assurance)</b>			
1. JCC/WAST Forward Plan for EMS and NEPTS in place and monitored at JCC meetings			1. Minutes of meetings and a standard agenda item			
2. JCC and its 2 sub-committees established as a forum to discuss WAST's strategy (sub-committees currently under review as part of move into JCC).			2. Minutes of meetings and a standard agenda item. Sub-committees now established, with report on commissioning arrangements to July Finance & Performance Committee.			
3. Weekly catch up between Interim Director of 111 & Ambulance Commissioning /CEO			3. Meetings are diarised every week			
4. Collaboration between JCC and WAST on specific projects e.g.			4. Representatives are co-opted onto meetings and frequency is between 3-6 weeks. Set agendas with NCCU reps co-opted.			
5.—			5. Note: this meeting has stopped and needs to be restarted, probably in a slightly different form. It is anticipated that this meeting will restart in its new form in the second half of 2025/26.			
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced			6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholder's fortnightly			
7. Commissioning intentions.			1. In year progress reported each quarter to the relevant commissioning meeting and 24/25 commissioning intentions approved for 111 Wales and expected to be approved by Mar-24 JCC (approved).			
8. Governance arrangements for 111 commissioning: 111 Board, 111 Commissioning Board + 111 DAG etc.			2. Minutes of meetings and a standard agenda item			
			<b>External Management (1<sup>st</sup> Line of Assurance)</b>			

Risk ID	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience		Date of Review:	19/08/2025	TREND	12
100			Date of Next Review:	14/11/2025	➡	(3x4)
		1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available				
GAPS IN CONTROLS		GAPS IN ASSURANCE				
1. JCC remit is wider than just ambulances and will reduce the agenda time dedicated to WAST's three patient pathways.		1. A shorter provider brief will go to the JCC with more detailed discussions taking place at its sub-committees. There is no provider brief going at this time, but the Trust does produce extensive slides for the bi-monthly WG Integrated Quality, Planning & Delivery accountability meeting, with the Director of Commissioning for Ambulance & 111 Services in attendance.				
2. Governance coordination between the JCC and WAST to be improved.		2. Identified need for a governance meeting between JCC and WAST to manage the overall commissioner/provider interface. Actioned, but has lapsed due to capacity and resourcing in NCCU team. This will be further reviewed as the JCC goes live in April-24 (period of transition likely to extend through Q1). This has lapsed at this time, but request to re-establish it sent to commissioners. This meeting has now been restarted and continues to function				
3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)		3. Ministerial direction on handover reduction with significant pressure being applied to health boards through the NHS Leadership Board and NHS Executive accountability arrangements. The Welsh Government target is no waits > one hour, which equates to 7,000 lost hours. WG has now established an Ambulance Patient Handover Improvement Implementation (APHID) Group to take forward this ambition. This has led to the W45 initiative i.e. 45 minute handover, with handover lost hours in July 2025 being their lowest since July 2021. A continued focus by health boards is required to achieve the ambition and sustain it.				
4. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control)		4. Strategic demand and capacity review completed and reported to Finance & Performance Committee. Whilst the Director of 111 & Ambulance Commissioning is sighted on the findings, it has not yet been formally reported to the JCC, in agreement with WAST. This remains the case.				
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:		
1. Agree and influence JCC/Health Boards that sufficient funding to be provided to WAST		CEO WAST	As part of 25/26 budget setting process in Q4 this year (18/03/25 F&P Committee). IMTP now with WG awaiting approval, timeframe dependent on WG.	26.06.24 Funding for a 32 FTE APPs secured for 2024/25 and 23.2 FTEs into Integrated Care. 06/08/24 WAST briefing on evolved CRM and 2023 EMS Demand & Capacity Review to JCC Board Development session in Aug-24. 21/01/25 ELT has considered the draft commissioning intentions and responded to the Director of Commissioning. 14/04/25 Commissioning intentions built into the Trust's 2025-28 IMTP with FTE additionality planned in the remote care and see & treat space. MAI scrutiny exercise on-going. Skills Mix Task & Finish on-going, due to report into ELT end of April 2025, no funding from JCC expected. 19/08/25 Q1 commissioning intentions reported to JCC sub-committee. EA Skills Mix paper went to ELT in June 2025 with further paper on 27/08/25.		
2. Agree and influence JCC/Health Board of the need for significant reduction in hospital handover hours		CEO WAST	IQPD 12/02/25 The APHID is a WG led group, so timeframe is dependent on WG.	26/04/24 This modelling has been further supplemented by modelling the Ministerial target of no handovers of more than one hour. 26/06/24 May-24 levels at 24,000, which is higher than 2023 and concerning as an indicator of the winter the Trust may expect. Trust moving at pace to evolve clinical response model, with Welsh Government full sighted on impact of handover hours on the Trust. 21/01/25 The Trust experienced 26,000 ambulance unit hours lost to hospital handover in December 2025, in line with its prediction, but significantly above the WG target of no waits over one hour, which equates to approximately 7,500 hours. 14/04/25 WG has now established an Ambulance Patient Handover Improvement Implementation (APHID) Group to take forward this ambition. 19/08/25 This has led to the W45 initiative i.e. 45 minute handover, with handover lost hours in July 2025 being their lowest since July 2021. A continued focus by health boards is required to achieve the ambition and sustain it.		
3. Increased understanding of NEPTS by JCC		Executive Director of Strategy Planning and Performance	02/08/23 30/06/24 20/08/24 21/02/25	16/04/24 Workshop arranged for April 2024 (completed). 26/06/24 Workshop results reported to newly established Interim Ambulance Commissioning Committee. 06/08/24 The WAST briefing to the JCC Board Development session in Aug-24 includes coverage of five workstreams, one of which is Health Transport, which includes NEPTS and UCS.		

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience		Date of Review:	19/08/2025	TREND	12
			Date of Next Review:	14/11/2025		(3x4)
		Timeframe tbc, subject to current discussion with JCC.	<p>21/01/25 Consideration of Future Vision for NEPTS at JCC meeting on 21/02/25.</p> <p>14/04/25 On-going discussions with JCC on the Future Vision, in particular, next steps, with possible development of a service blueprint connected to the Vision.</p> <p>18/08/25 The Director of Commissioning for Ambulance &amp; 111 Services has raised a concern about the level of capacity management cancellations and asked for options for mitigating these, which the Trust is currently exploring.</p>			
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	02/08/23 Checkpoint Date Timeframe for establishing a replacement for CASC Assurance is a JCC responsibility.	<p>30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue. 02.05.23 These have lapsed due to pressures and sickness absence in the NCCU. HB to reboot, subject to ability of NCCU to undertake. 28.07.23 Availability remains a challenge, but there is regular informal dialogue between WAST and NCCU. 18.01.24 This specific meeting remains lapsed, but the Trust is currently meeting every two weeks with the NCCU on the development of the IMTP. As the Trust moves into the new JCC from 01 April 2024 there will be a further opportunity to address this control.</p> <p>16/04/24 The new commissioning arrangements are in transition and still quite fluid at the moment.</p> <p>26/06/24 Request to commissioners to re-establish this meeting.</p> <p>06/08/24 Meeting now re-established. 21/01/25 Meeting continues to operate.</p> <p>14/04/25 Meeting continues, but the monthly CASC Assurance meeting has lapsed and needs to be restarted. This is anticipated by the Trust but is dependent on the Director of 111 &amp; Ambulance Commissioning discussion with JCC colleagues.</p> <p>19/08/25 As above, the WG IQPD meeting operates bi-monthly and provides an accountability mechanism, but the Trust is anticipating the resumption of a JCC mechanism in the second half of the year.</p>			
5. Develop and roll out the Stakeholder Influencing Plan	Director of Partnerships & Engagement AD Planning & Transformation	<b>Q2 24/25 onwards</b>	<p>15/03/24 This action is captured in Risk 201 on the CRR. The reputation audit being repeated in Q1 will inform the development and roll out of this plan in Q2.</p> <p>14/04/25 The CMT Programme Engagement Plan (PEP) is live. During Q4 the programme has undertaken a series of priority engagement sessions with key clinical groups and stakeholders on the Clinical Services Model proposals. The next steps are to undertake wider system engagement.</p> <p>19/08/25 System wider engagement was undertaken as part of the phase one Ambulance Performance Framework go live on 01 July, with further communications planned as part of the phase 2 go live on 01 December 2025.</p>			

<b>Risk ID</b> 163	<b>Maintaining Effective &amp; Strong Trade Union Partnerships</b>			<b>Date of Review:</b>	15/10/2025	<b>TREND</b>	12 (4x3)
				<b>Date of Next Review:</b>	15/01/2025	➡	
<b>IF</b> the response to tensions and challenges in the relationships with TU partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained	<b>THEN</b> there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	<b>RESULTING IN</b> a negative impact on colleague experience and/or services to patients			<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
				<b>Inherent</b>	5	3	15
				<b>Current</b>	4	3	12
				<b>Target</b>	4	3	12
IMTP Deliverable Numbers: 1, 13, 14, 19, 22, 30, 32							
Strategic Objective:							
<b>EXECUTIVE OWNER</b>		Director of People		<b>ASSURANCE COMMITTEE</b>		People & Culture Committee	
<b>Risk Commentary</b>							
<p>A tailored bespoke development programme for managers and Trade Union Partners at all levels has been delivered with further training and activities to be developed for first line managers. The programme of engagement and relationship building will continue throughout 2025/26.</p> <p>Work continues on improving partnership working through the delivery of the action plan. The engagement structures below WASPT are in place and running. The Deputy Director of People and Head of Culture and OD have delivered workshop sessions for TU partners and managers across the organisation in senior and local roles. Personal relationships with TUPs are generally very good. At a local level there are ongoing discussions on a range of organisational change issues and currently engagement and partnership working is operating well and as a result the score has been reduced to 12 (3x4) . However, there is a recognition that the nature of partnership working and the issues that arise mean that the level of risk fluctuates more regularly than others and will be kept under review. It is noted that work required on financial sustainability to meet savings requirements and projects such as reviewing the skill mix has the potential to disrupt relationships and may lead to a review of the score. Also, the departure of the CEO may cause some concerns amongst TU partners in terms of the risk of a change in approach to partnership working. On a national level, TUPs have not confirmed acceptance of the 2025 pay offer of 3.6% and there is a risk for industrial action.</p>							
<b>CONTROLS</b>				<b>ASSURANCES</b>			
				<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. Agreed (Refreshed) TU Facilities Agreement developed in partnership				1. Agreed document which states governance arrangements and the criteria for time off for TU activity etc.			
2. Go Together Go Far (GTGF) statement and CEO/TU Partners statement				2. Both parties refer to the documents and are signed up/committed to it			
3.				3.			
4. Trade Union representation at Trust Board, Committees				4. Committee or Board ask TU representative for feedback or whether they have been consulted. Big issues items progress as planned because of TU partner buy in			
5. Monthly Informal Lead TU representatives and Chief Executive meetings				5. Diarised meetings			
6. TU partners in Task & Finish and Project Groups				6. Good attendance and commitment are observed at the meetings. TU partners listed as members in terms of reference			
				7. Diarised meetings with a formal agenda. Any business needed to be discussed is included in the agenda. Good attendance and commitment observed at meetings.			
7. Local Partnership Forums, Corporate Partnership Forums and SLT/TUP and SOT/TUP well established and running and informal monthly meetings between TUPs and Senior Operations Team in place and operating				8. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings			
8. Quarterly Report on TU activity to People and Culture Committee				9. Report at every P& C committee meeting regarding activities TUPs involved with which is noted. Whenever Partnerships are discussed, the value of these is formally minuted in the Board and Committee minutes			
9.				10. Triple A reports through to WASPT and to PCC. Any escalations are appropriately noted.			
11. Ongoing project plan in place to support the improvement in relationships based on the ACAS report from 2022 updated and reported to WASPT				11. Development of mentoring and training opportunities for TUPs to support their roles.			
12. AAA report of formal Partnership Forum (WASPT) reported to PCC or Board in future (return to BAU).				12. Training for managers and TUPs delivered			
13. AAA from SLT Partnership Forum and Corporate Partnership Forum reported to WASPT				13. Stability in senior TU team			

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	15/10/2025	TREND	12
		Date of Next Review:	15/01/2025	→	(4x3)
14. Externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree. Completed	14. Action plan developed and shared with TUPs. Implementation underway. A series of partnership working sessions (5) have been delivered to around 120 colleagues – managers and TU partners. Feedback from the sessions was captured and next steps were reviewed. Completed There is an ACAS action plan which is a live doc and is reported to WASPT to update progress.				
15. Rhythm of meetings to curate and focus on relationships	15. AAA, minutes, monthly sessions with CEO, DoP and DoO. Informal sessions with CEO, DoP and Branch Chair and Sec on a quarterly basis. 6 weekly meetings with DoP on other partnership forum arrangements.				
16. Increased mutual respect and TU partner understanding and appreciation of challenges and pressures facing the Trust					
17. Rollout of partnership training across WAST now to be extended to first line managers					
18. Observation of partnership forums and development work on embedding partnership training is ongoing. Additional actions have been added to the action plan, and WASPT was updated on 27.01.25.					
19. Consider how we celebrate success and capture the positive learning	Captured as part of social partnership conference and subsequent comms But BAU in terms of partnership approach				
20. Delivery of Social Partnership Conference – completed					
21. Task and Finish group to be established to work on mitigating the impact of EAP Band 5 post introduction and wider skill mix discussions.	Email to TUPs from Director of Strategy and Planning. Meetings completed business case in development for feedback to ELT				
22. Output from Conference informing next steps in developing maturity of relationship					
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>			
1. In maintenance and further improvement mode	None identified				
2.					
<b>Actions to reduce risk score or address gaps in controls and assurances</b>	<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>		
1. Refresh of engagement programme post Industrial Action and establish work	Deputy Director of People	Q2 2025/26	Plan agreed and being monitored via WASPT. The plan is dynamic with actions being completed and additional actions added to the plan as they arise. Draft training development underway in partnership with TUPs – list of training needs shared from TUPs. - Completed Principles on engagement being developed (in part from the training) and as a result the partnership statement will be updated. eLearning courses created by WG Social Partnership Team to be added to Learn365 Further session of partnership training to be scheduled in Q2 2025/6 Development of learning events for first line managers including content in Our WAST Way <b>Task and Finish group to develop a partnership development day for first line managers has been re-established and work is underway.</b>		
2. Learning and Development opportunities for TU partners e.g. shadowing, digital skills, coaching and mentoring	Deputy Director of People	31/03/25 30.09 25	Awaiting refresh of the online learning by WG prior to publishing in WAST. <b>Online learning on 365 published and advertised via Siren</b>		
3. Develop consultation guidance for managers	Deputy Director of People	31/06/25 30/12/25	Date pushed out due to team capacity.		
4. Produce a report for ELT with a range of options on Skills Mix	Director of People	31/05/25 30.06.25 31/08/25 <b>(completed)</b>	Delay due to extended discussions with TUPs and second report for ELT in August 25 Second report provided in August. <b>Third report provided in September including a QIA and EIA completed and shared back to ELT with a risk register and communications strategy.</b>		

<b>Risk ID</b> 139	<b>Failure to deliver our Statutory Financial Duties in accordance with Legislation</b>	<b>Date of Review:</b>		13/08/2025	<b>TREND</b>	8 (2x4)	
		<b>Date of Next Review:</b>		13/11/2025			
<b>IF</b> the Trust does:		<b>THEN</b> there is a risk that	<b>RESULTING IN</b>		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
<ul style="list-style-type: none"> <li>not achieve financial breakeven and/or</li> <li>does not meet the planning framework requirements and/or</li> <li>does not work within the EFL and/or</li> <li>fails to meet the 95% PSPP target and/or</li> <li>does not receive an agreement with commissioners on funding</li> </ul>		the Trust will fail to achieve all its statutory financial obligations, and the requirements as set out within the Standing Financial Instructions (SFIs)	potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage		<b>Inherent</b> 3	<b>4</b>	<b>12</b>
					<b>Current</b> 2	<b>4</b>	<b>8</b>
					<b>Target</b> 2	<b>4</b>	<b>8</b>
IMTP Deliverable Numbers: 9, 12, 15, 18, 24, 25, 30, 31, 32							
Strategic Objective:							
<b>EXECUTIVE OWNER</b>		Executive Director of Finance and Corporate Resources	<b>ASSURANCE COMMITTEE</b>	Finance and Performance Committee			
<b>Risk Commentary:</b> To end of <b>September</b> 2025 of the 2025/26 financial year. The risk has now been further reviewed in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to WG year to date to Month <b>6</b> of the 2025/26 Financial Year. The score is consistent with that of Qtr. <b>2</b> 2025/26 due to presenting an opening balanced financial plan for 2025/26, full allocation of the £8.5m savings delivery target and YTD overachievement. Reported Financial position is currently in deficit (£0.186m) but revised year end forecast is one of balance. It must be noted though that clear monitoring of the savings target for 25/26 will be needed as this is £2m increase from the 24/25 delivered position and also the recovery of the current deficit albeit in a challenging financial climate for all public sector organisations.							
<b>CONTROLS</b>				<b>ASSURANCES</b>			
				<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. Financial governance and reporting structures in place				1. Risk is reviewed quarterly at FPC, and a report is submitted bi-monthly to Trust Board			
2. Financial policies and procedures in place							
3. Budget management meetings				3. Diarised dates for budget management meetings and delegation of budgets			
4. Regular financial reporting to ADLT, EFG, ELT, FPC and Trust Board in place				4. Diarised dates for ADLT, FPC and Trust Board and monthly reports with budget managers. <b>EFG meeting held late July and August 25</b>			
5. Welsh government reporting				5.			
6. Monthly review of savings targets				6. ADLT updated via core reporting. Reporting included in finance reports to committees and boards			
7. Regular review monitoring and challenge via WAST and JCC / CASC quality and delivery meeting with commissioners.							
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.				8. Diarised dates for ICMB meetings with regular monthly report			
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications				9. Regular PSPP communications (Trust wide) on Siren			
10. Forecasting of revenue and capital budgets				a) Monthly monitoring returns to ADLT, ELT (EFG) and FPC (b) Reliance on available intelligence to inform future forecasting.			
11. Business cases and benefits realisation (both revenue and capital)				11. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, ELT, FPC prior to Trust Board for approval as appropriate according to value.			
				<b>External Assurances Management (1<sup>st</sup> Line of Assurance)</b>			
				5. Monthly Monitoring Returns to Welsh Government			
				7. JCC management meetings and at bi-monthly meeting with JCC Finance teams			
				8. Capital meetings with Trust and WG capital leads			
				9. Regular P2P meetings diarised (bi-monthly)			
				10. Monthly monitoring returns into Welsh Government			
				<b>Independent Assurances (3<sup>rd</sup> Line of Assurance)</b>			
				1-10 Internal audit reviews covering			

<b>Risk ID</b> 139	<b>Failure to deliver our Statutory Financial Duties in accordance with Legislation</b>	<b>Date of Review:</b>	13/08/2025	<b>TREND</b>	8 (2x4)
		<b>Date of Next Review:</b>	13/11/2025		
		1-10 External audit reviews			
<b>GAPS IN CONTROLS</b>			<b>GAPS IN ASSURANCE</b>		
1. Lack of formalised service contracts between Commissioner and WAST as a commissioned body			1. None identified.		
<b>Actions to reduce risk score or address gaps in controls and assurances</b>	<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>		
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/25 31/03/26	Supported financial plan included in IMTP for 25/26. At least bi-monthly meetings with WAST finance and JCC in relation to contract payments.		
2. Embed a transformative savings plan and ensure organisational buy in	Savings subgroup / FSP	31/03/25 31/03/26	The Financial Sustainability Program (FSP) will continue to be a key vehicle for the Trust to monitor and develop its savings program. Over delivery was achieved for the 24/25 financial year and the point of strong delivery is further highlighted with the programs ability to fully identify the 25/26 £8.5m savings plan before the start of the financial year.		
3. Embed value-based healthcare working through the organisation	Executive Leadership Team and Value Based Healthcare Group	31/03/25 31/03/26	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.		
4. Foundational economy, Decommissioning, and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/25 31/03/26	The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best value for money while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales. Ad hoc reports are received from Shared Services on WAST's progress in switching more expenditure to Welsh suppliers to keep the Welsh pound in Wales.		

Key - List of Strategic and IMTP objectives

<b>Strategic Objective 1: Providing the right care or advice, in the right place, every time</b>		<b>BAF risks</b>
1.	A modern, easily accessible, user-friendly and integrated digital offer	223, 224, 623, 260, 201,163
2.	Rapid (111) call answering, initial triage and onward referral	223
3.	Timely, high quality clinical assessment, advice and referral	223, 224
4.	Seamless transfer of 111 callers to wide range of available pathways	223
5.	Immediate 999 call answering, and efficient and effective dispatch of the right resource	223
6.	High quality, timely, clinical triage, assessment and consultation, with personalised response	223
7.	High quality, immediate or timely on scene assessment, care and conveyance where needed	223, 100
8.	A range of 24/7 pathways available for further assessment or treatment, closer to home	223, 224
9.	A flexible, user-centred Non-Emergency Patient Transport Service with the right capacity in place to meet demand	100,139
10.	A dedicated and timely transfer & discharge service supporting HBs with their transformation agendas	223
11.	A clear vision for Ambulance care services that supports wider health and care transformation	100, 201
12.	A high quality, safe (NEPTS) service with improved patient experience	100, 139
<b>Strategic Objective 2: Enabling our people to be the best they can be</b>		
13.	Culture: <ul style="list-style-type: none"> <li>Enhance and strengthen internal capacity for delivering culture change</li> <li>Develop amplify employee voice to increase employee engagement</li> <li>Continue the implementation of our compassionate practices approach</li> </ul>	160, 558, 623, 201, 163
14.	Capacity: <ul style="list-style-type: none"> <li>Implement our Strategic Workforce Plan</li> <li>Continue to embed a culture of positive attendance management</li> <li>Continue our focus on 'getting the basics right.'</li> </ul>	100, 160, 163, 223, 224, 558, 594, 623
15.	Capability: <ul style="list-style-type: none"> <li>Grow and develop our leadership and management capability</li> <li>Reinforce and promote career pathways and professional development.</li> <li>Create an environment centred around effective, ongoing conversations ('Check Ins')</li> </ul>	100, 139, 160, 223, 224, 260, 594
16.	Strengthen Welsh Language compliance through strong leadership, enabling Welsh language to flourish	201
<b>Strategic Objective 3: Being at the forefront of innovation and technology</b>		
17.	The right buildings in the right place, enabling our staff to provide the best and safest care across Wales	542
18.	The right fleet in the right place, enabling our staff to provide the best and safest care across Wales	139, 542, 623
19.	Develop & agree Digital Plan <ul style="list-style-type: none"> <li>Everyday essentials</li> <li>Security, Safety &amp; Cyber</li> <li>Digital Pioneers</li> <li>Transformation</li> <li>Data, Information &amp; Insight</li> </ul>	163, 260, 623
<b>Strategic Objective 4: Developing services in collaboration</b>		
20.	Well-placed to influence system thinking / strategy development	100, 223
21.	Meet the requirements of the Wellbeing of Future Generations Act	558
22.	University Trust Status in collaboration with WG, embracing a 'democratised culture' of learning, research and innovation	160, 163, 223, 224
<b>Strategic Objective 5: Being quality driven and clinically led</b>		
23.	Systems that meet the requirements of the Duty of Quality and Duty of Candour	224
24.	Excellent clinical leadership	100, 139,160, 223, 224, 260, 594
25.	A culture of quality improvement with robust quality management systems	100, 139, 160, 201, 223, 224
26.	High quality Putting Things Right, Safeguarding and Health & Safety systems	160, 224, 558
27.	Meaningful engagement and co-production with communities	223, 224
28.	A risk management framework as a key enabler of our long-term strategy and decision making	No corporate/principal risks
29.	An integrated governance framework	No corporate/principal risks
<b>Strategic Objective 6: Delivering exceptional value</b>		
30.	Sustainable savings & efficiencies	139, 163, 224
31.	Generate income alongside our core commissioned functions	139, 224
32.	A Value-Based approach across the organisation which is embedded in culture	100, 139, 163
33.	Developing and implementing our plans for Environmental Sustainability and Adaptation	542

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596	22/23	Audit	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	1.1	Following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements	1.1	Accepted. Formal risk appetite statements will be developed in conjunction with the transformational BAF in 23/24; however, the risk consequence matrix is in place and includes risk appetite across a range of categories. The Trust sets out its risk appetite for patient harm in its annual report. This action forms part of the risk management transformation programme monitored at the Strategic Transformation Programme Board. Additionally, a Board Development Session is planned for February 2024.	Jun-24	Not Met	Mar-25	Jul-25		Closed in Quarter	<a href="#">25/26 Q2 Update</a> 081025 (IB): Action proposed for closure. All six Risk Appetite Statements (RAS) considered at Board Development Day (BDD). These will be presented to the Trust Board on 27/11/25 for formal approval, and the implementation plan is on the Audit Risk and Assurance Committee (ARAC) agenda for 02/12/25.
656a	22/23	FPC	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(b)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(b)	Should [following the review at 3.1a being evaluated] we still need space at Denbigh County Council then we will pursue an agreement with them for those storage, retention and disposal. In the meantime, we will ask for the policies and procedures the Council have in place for their receipt, retention and destruction of records and confirm that this is the way they treat our records. That should provide some assurance on the issues in the matter arising.	Sep-24	Not Met	Mar-25	Jul-25		Open	<a href="#">25/26 Q2 Update</a> 221025 (LT): No update supplied. Action already on its 2nd Revised Date therefore Director of Digital to be asked to attend ARAC to provide update and assurance.
668	23/24	Quest	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Clare Appleton	Liam Williams	Medium	1.1	The Trust's 'Adverse Incident and Reporting Policy' should be reviewed and updated to reflect the requirements set out within the NHS Wales policy.	1.1	The Putting Things Right Team plan was to review relevant policies following the release of the new Putting Things Right Regulations by Welsh Government in May 2024. A recent update from Welsh Government has confirmed that the release will now be Autumn 2024. At which point the review will be undertaken. The Trust has approved policies in respect of incident reporting and management and a Putting Things Right Policy which are included on the intranet site (review dates are both April 2026). Staff also have access to User Guides on the intranet site for Datix Cymru.  The All-Wales Patient Safety Policy (NHS Executive) (May 2023) is also due review in March 2024 and will be updated internally when released nationally	Nov 24	Not Met	Dec-25		Open	<a href="#">24/25 Q4 Update</a> <b>230325 (CA)</b> No further updates have been received for release/implementation date of the revised Putting Things Right Regulations. There is no change to the timescales provided in the last update - action remains on track for completion by Dec25.  <b>200125 (LT)</b> ADLT noted 1st revised date (Dec25)  <b>061224.</b> The Putting Things Right Regulations by Welsh Government are yet to be updated. The latest position provided by the Stakeholder Reference Group is for Autumn 2025. The proposal is to move deadline date to December 2025 to allow for Policy rewrite and approval post national release. The NHS Wales Executive have confirmed to the HOPE Network on 27 November 2024 that there is no anticipated revision of the National Patient Safety Incident Policy.	
681	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Keith Dorrington	Jonny Sammut	Medium	1.1	To confirm accuracy of the self-certification compliance rate, management should consider capturing the method of training delivery on ESR.	1.1	For future training, the method of instruction will be captured as part of the ESR sign-off process (for example, classroom based, individual learning using the training materials, one to one instruction using the training zone in the application).	Jun-24	Not Met	Sep-24	Mar-25	Apr-26	Open	
683	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Keith Dorrington	Jonny Sammut	Medium	1.3	Management should consider including a test in ESR to confirm competency before successfully self-certifying.	1.3	At the ePCR CRG WAST will discuss including a test to assess understanding at the completion of training.	Jun-24	Not Met	Sep-24	Dec-24	Apr-26	Open	<a href="#">25/26 Q1 Update</a> <b>240625 (KD)</b> Please see update recorded against Action 681. Previous 3rd/Final Revised Date amended to Apr26.
684	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Keith Dorrington	Jonny Sammut	Medium	1.4	Whilst we acknowledge there are different methods of training delivery, management should review lower viewed training modules, to confirm that the completed ePCRs are compliant with expectations in this area.	1.4	Through the ePCR Clinical Reference Group (CRG) we will review the lower viewed modules as set out in Appendix B of this report. This will build on knowledge discussed at the most recent ePCR CRG where a small audit has identified that the obstetric section is not being completed. However, we currently have only opened access to the Welsh GP Record (WGPR) for our cohort of Advanced and Senior Paramedics. The pathways section of the ePCR is not currently live and requires testing prior to going live, which explains the disparity reported in these sections of Appendix B.	Sep-24	Not Met	Dec-24	Mar-25	Apr-26	Open	<a href="#">25/26 Q1 Update</a> <b>260725 (LT)</b> Previous 3rd/Final Revised Date of May25 amended to Apr26.  <b>240625 (KD)</b> Meeting held with OL (IA) 160625 to discuss remaining ePCR related audit actions and agree a way forward. Clinician metrics: Initial development work is complete on the Tenant structure; we are now building into the application the next phase which is the clinician names next to key interventions. The proposed final go live date for both individuals and managers reporting is 31st March 2026. However, whilst we will report on the above information prior to that date the work is very much iterative and continual development will be required.
686	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Keith Dorrington	Jonny Sammut	High	2.2	Management should ensure the tenant structure is developed to provide data at both a team and individual level to assist in identifying training needs and drive improvement in ePCR compliance.	2.2	Reporting into CIAG, we will set up a Task and Finish Group to write the plan to deliver the dashboards against the Tenant Structure. This is a complex piece and requires input from multiple directorates. It is also dependent on the capacity within teams to deliver the dashboards, therefore the output of the T&F might be a business case jointly developed between the Digital and Clinical Directorates to outline the resources required and what this would cost to deliver.	Sep-24	Not Met	Mar-25	Sep-25	Apr-26	Open	<a href="#">25/26 Q2 Update</a> 221025 (LT): When the outstanding actions relating to this audit were discussed earlier in the year, the completion date for this action remained unchanged. In hindsight this should have been extended to April 2026 in line with the other three remaining actions. Therefore, as an exception, a 3rd Revised Date (Apr26) has been applied.  <b>021025 (KD):</b> The Clinical Tenant structure is complete, Operations have now requested that we build a structure aligned to the DQM's team makeup. completion of this build is November 2025. There will be further work needed on the portal frontend to allow the movement of teams members. completion of this element is due Jan 2026.

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635	23/24	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	1.1	Noting that roles and responsibilities will have changed since the national NHS 111 Wales service has been implemented, roles and responsibilities should be clearly detailed within the National Collaboration Agreement and signed by both parties (Commissioner and Trust). Opportunities should be provided for partners to reflect on their roles and functions regularly so that the Agreement can be amended to reflect any changes.	1.1	A new joint Commissioning Committee will come into effect from 01/04/24. The Trust wants to wait and see what develops in this space rather than commit time to a document that could cease on the 31/03/24.	Apr-24	Not Met	Jun-25	Dec-25		Open	
691	23/24	FPC	ICT Contract Management	Reasonable	Robert Walker	Jonny Sammut	Medium	3.2	ICT contract management process should be applied to all ICT related contracts, with the ICT Contract Manager feeding into any management meetings within other areas.	3.2	The Contract Management [SOP] process is to be applied to all contracts listed in the contracts register.	Mar-25	Not Met	Sep-25	Sep-26		Open	<a href="#">25/26 Q2 Update</a> 111125 (AW) 2nd Revised Date of Mar26 will be challenging to achieve given volume of work concluding ongoing contract renewals and finalisation. Potential additional resources being considered to accelerate adoption to meet recommendation. Agreed 2nd Revised Date of Sep26.
701	23/24	Qest	Clinical Audit	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.1	The Trust should ensure appropriate detail in relation to clinical audit is included and documented it within its organisational documents.	1.1	There are workshops scheduled (4th, 9th and 10th July 2024) to plan the next iteration of the Trust clinical strategy. The Clinical Directorate will ensure that clinical audit is given the space it needs to articulate the need for, and link to the guidelines on how to undertake an audit in the final approved document. Where update presentations are given up to, and including, board level meetings, the Clinical Directorate will ensure clinical audit is included. The clinical strategy will articulate clearly how clinical audit meets HQIP standards and will link to the clinical audit plan (for example, to the Clinical Audit section on the Trust intranet).	Mar-25	Not Met	Jun-25	Sep-25		Closed in Quarter	<a href="#">25/26 Q2 Update</a> 240925 (JL) - Proposed for closure. Evidence supplied: CIA Clinical Plan.
712	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.1	The Trust should ensure the distribution of received guidance in relation to fundraising to the full CFR population.	4.1	On receipt of any guidance on fundraising, the National Volunteer Manager will within one month, convene a Task and Finish Group, under the governance of the Operations Directorate. The T&FG will be tasked with cascade of any guidance to volunteers	Mar-25	Not Met	Aug-25			Closed in Quarter	<a href="#">25/26 Q2 Update</a> 120925 (TMN): SOP finalised and approved at SOT 26/08/2025. The SOP and Good practice documents will be shared with Volunteers w/c 15/09/2025. The Head of Charity will also be presenting these documents in the Volunteer Conference. Propose Closure of the actions. Evidence supplied to support proposed closure.
714	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.3	The Trust should consider the development of good practice documents to support donation fund management, which could be incorporated into CFR team constitutions and processes.	4.3	The T&FG will be responsible for execution of the actions described at 4.1-4.4. Any issue escalation to be reported through ADLT to ELT, noting it is not yet possible to determine the outputs from the T&FG, including the risk owner.	Mar-25	Not Met	Aug-25			Closed in Quarter	<a href="#">25/26 Q2 Update</a> 120925 (TMN): SOP finalised and approved at SOT 26/08/2025. The SOP and Good practice documents will be shared with Volunteers w/c 15/09/2025 and will also go through SOT for noting. The Head of Charity will also be presenting these documents in the Volunteer Conference. Propose Closure of the action. Evidence supplied to support proposed closure.
715	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.4	The Trust should prioritise the completion of a Volunteer fundraising risk, including clarifying the ownership of the risk within the Trust.	4.4	The T&FG will be responsible for execution of the actions described at 4.1-4.4. Any issue escalation to be reported through ADLT to ELT, noting it is not yet possible to determine the outputs from the T&FG, including the risk owner.	Mar-25	Not Met	Aug-25			Closed in Quarter	<a href="#">25/26 Q2 Update</a> 180925 (TMN) - SLT has confirmed that the SOP and Good Practice Documents are in place. It has therefore been agreed that the documents serve as treatment for the risk, negating the need to raise a separate risk. SLT propose closure of this action. Evidence supplied to support proposed closure.
726	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	10.1	The Trust should confirm a consistent selection criterion for the selection of claims to be validated which includes risk assessment and adequate coverage of outliers.	10.1	The Trust will agree a consistent selection criterion for validation of checks, to include risk assessment and coverage of outliers.	Oct-24	Not Met	Mar-25	Jul-25		Closed in Quarter	<a href="#">25/26 Q2 Update</a> 12092025 (TMN) The paper was taken to SOT however not approved due to financial queries. Volunteer manager met with Finance to gain further financial assurance. Paper going back to SOT w/c 15th September for approval. Propose Closure of the actions. Evidence supplied to support proposed closure.

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003-24/25	2024/25	FPC	Data Quality	Reasonable	Head of Information	Jonny Sammut	Medium	2.1	Management should consider assessing the digital literacy of all staff and developing data quality awareness training to complement the newly updated Data Quality Policy.	2.1	A full programme for assessing & improving Digital Literacy is planned for Tranche 2 (i.e. 2025-26) under the refreshed Digital Plan. In the meantime, a Data Quality awareness training module will be made available across the Trust via an existing platform (i.e. ESR, LMS365 or MetaCompliance – tbc) to minimise any additional cost.	Dec-24	Not Met	Apr-25	Oct-25		Closed in Quarter	25/26 Q2 Update: 240925 (LS) A Data Quality training module has been developed in-house, as a collaboration between the Insight & Data Services and Education teams. This module will be made available to all WAST staff in October 2025 via LMS365, and monitoring of uptake will be conducted by the IG Steering Group (a KPI will be added to the regular reporting to track). Propose for closure.  Evidence supplied: Screenshot of module - expected launch by mid Oct25
004-24/25	2024/25	FPC	Data Quality	Reasonable	Leanne Smith	Jonny Sammut	High	3.1	Management should ensure that the Information Asset Register accurately reflects the Trust's information landscape to ensure that a singular, consistent catalogue of information assets is in place to monitor compliance and efficiency.	3.1	IGSG has already agreed to establish an Information Asset Owners Group. This sub-group will be responsible for the further development and ongoing maintenance of the Trust's Information Asset Register. Until the two vacant Data Protection Compliance Manager posts are filled (expected November 2024) there is not capacity within the IG function to help establish and run such a group.	Apr-25	Not Met	Sep-25			Closed in Quarter	25/26 Q2 Update: 240925 (LS) To ensure we maintain an accurate register long-term, an IAO group has been established. Terms of Reference devised, membership confirmed, and meeting planned for October 2025. This item is proposed for closure, however the evidence of the AAA reported through to IGSG will not be available until after the meeting of the November IGSG given meeting cycles / timelines.  Evidence supplied: Draft TOR (endorsed by IGSG) and Draft Agenda for the meeting group. IGSG AAA noting discussion of first meeting of Information Asset Owners Group is to follow following Oct25 IGSG Meeting.
009-24/25	2024/25	FPC	Data Quality	Reasonable	Leanne Smith	Jonny Sammut	Medium	5.4	Management should ensure reportable data quality KPIs are developed and are appropriately reported.	5.4	A monthly KPI report passes through IGSG, already with a placeholder for Data Quality metrics. The development of these metrics is dependent upon recruitment into the proposed new DQ posts.	Apr-25	Not Met	Jul-25			Closed in Quarter	240925 (LS) Data Quality metrics have been developed against the DQ domains. These have been reported to IGSG for a couple of months, and from September 2025, were also included in the Digital KPI reporting to Finance & Performance committee, receiving good feedback. Action proposed for closure. The reports presented at IGSG and at FPC are given as evidence.  Evidence supplied: - FPC: Digital Reporting Metrics (full report & screenshot) - FPC: Appendix 1 Digital Reporting Metrics (full report & screenshot) - IGSG: Information Security & Governance reporting (full report & screenshot)
013-24/25	2024/25	FPC	Overtime Controls	Reasonable	Liz Wedley	Lee Brooks	Medium	2.1	Consideration should be given to whether it would be possible to automate parts of the process, to reduce the amount of manual input by managers.	2.1	The Trust accepts this recommendation. Electronic timesheet development and implementation is a feature of the current IMTP. Scope work has begun in this financial year, however progress on implementation is expected to be in 2025/26 provided it is included in the forthcoming IMTP.	Mar-26	Not Yet Due				Open	25/26 Q2 Update: 120925 (TMM) Technical specification for Terms and Conditions in the E-timesheet Project Group is being considered for development. Total Mobile Solutions will be building this, however this may delay the project due to the nature of the build required, further update will be given in Q3.
014-24/25	2024/25	PCC	Resourcing Policy	Limited	Siobhain Frain	Lee Brooks	High	1.1	The mapping exercise should be completed to ensure that all local arrangements or differences in application of the Policy are appropriately recorded.	1.1	Resourcing Policy allows for local arrangements, which results in variation of process across the Trust which currently is not quantified. Resourcing will complete the process mapping and documentation of all local arrangements and differences in the application of the Policy across operational HUs by function. This will be submitted via the Resourcing monthly management team meetings.	Nov-24	Not Met	Jun-25	Mar-26		Closed in Quarter	25/26 Q2 Update: 120925 (TMM) Process mapping undertaken. A paper summarising the findings submitted 02/09/2025 for review at the Resourcing Management meeting. The variations identified in the process mapping are informing the development of the functional SOPs. Proposed for closure. Evidence supplied to support proposed closure.
015-24/25	2024/25	PCC	Resourcing Policy	Limited	Siobhain Frain	Lee Brooks	High	1.2	The functional SOPs for each area should be completed, approved and communicated to all staff.	1.2	Resourcing will construct departmental Standard Operating Procedures to support consistent application relevant to individual functions. SOT will review and agree each of the SOPs will be published and communicated to staff and resourcing teams.	Mar-25	Not Met	Sep-25	Sep-26		Open	25/26 Q2 Update: 101125: (LT) Update from JE in Operations - Agreed with LB that 3rd revised date to be amended from Mar26 to Sep26 to afford sufficient space and capacity to engage with TUPs on the changes. Work has commenced on the draft changes - there are 5 specific areas to be agreed including TOIL which is currently in the pilot stage.  221025 (LT) 2nd Revised Date of Mar26 applied. Executive Director of Operations to be asked to attend ARAC to provide update and assurance.  120925 (TMM): 111 SOP work in progress aligned with GRS to 111/Optahift project - EMS Coordination draft document with Phil/Gill, TU engagement required - Ambulance Care – awaiting response from Senior TUP for T&F reps - EMS – SOP not yet started <b>PROPOSE EXTENSION TO MARCH 2026</b>
016-24/25	2024/25	PCC	Resourcing Policy	Limited	Jonathan Edwards	Lee Brooks	High	1.3	The Resourcing Policy should be reviewed and revised (or re-defined), approved at an appropriate forum and communicated to all staff.	1.3	The Trust accepts this recommendation, and the Resourcing Policy will be reviewed and revised. A Resourcing Policy Group, in partnership with Trade Unions, will convene to review the existing policy. Governance arrangements including SOT, SLT and ELT will ensure changes are agreed and recorded.	Oct-25	Not Yet Due	Sep-26			Open	25/26 Q2 Update: 101125: (LT) Update from JE in Operations - Agreed with LB that 3rd revised date to be amended from Mar26 to Sep26 to afford sufficient space and capacity to engage with TUPs on the changes. Work has commenced on the draft changes - there are 5 specific areas to be agreed including TOIL which is currently in the pilot stage.  221025 (LT): 1st Revised Date of Mar26 applied.  120925 (TMM) T&F Group will be established to focus on this action however dates to be confirmed - PROPOSE EXTENSION TO MARCH 26
019-24/25	2024/25	PCC	Resourcing Policy	Limited	Jonathan Edwards	Lee Brooks	Medium	3.1	The process for TOIL should be reviewed, revised, agreed and communicated to provide clarity for both the Resource co-ordinators and staff.	3.1	The process for agreeing TOIL will be reviewed, revised, agreed and communicated as part of the Resourcing Policy review. See Management Action response 1.3). This will provide clarity for both the Resource Co-ordinators and staff.	Oct-25	Not Yet Due	Sep-26			Open	25/26 Q2 Update: 101125: (LT) Update from JE in Operations - Agreed with LB that 3rd revised date to be amended from Mar26 to Sep26 to afford sufficient space and capacity to engage with TUPs on the changes. Work has commenced on the draft changes - there are 5 specific areas to be agreed including TOIL which is currently in the pilot stage.  120925 (TMM) T&F Group will be established to focus on this action however dates to be confirmed, this lines up with the resourcing policy action - PROPOSE EXTENSION TO MARCH 26

022-24/25	2024/25	PCC	Resourcing Policy	Limited	Siobhain Frain	Lee Brooks	Medium	5.1	The Trust should ensure that performance against all expected timeframes within the Resourcing Policy are reported and monitored.	5.1	The Trust accepts this recommendation. The KPIs listed within the report are based on the existing resourcing policy. A reporting framework will be developed as part of the Resourcing Policy Review (see Management Action response 1.3). There are however two areas that have been completed or superseded as per below.  Action 5.1c - visibility of vacant shift. This functionality exists and is evident within the GRS system options. <b>This is complete.</b>  Action 5.1 d & e. Availability and acceptance of overtime - These KPIs are no longer applicable due to the implementation of the overtime allocation SOP and Financial Savings Plan.	Oct-25	Not Yet Due	Sep-26			Open	25/26 Q2 Update: 101125 (LT) Update from JE in Operations - Agreed with LB that 3rd revised date to be amended from Mar26 to Sep26 to afford sufficient space and capacity to engage with TUPs on the changes. Work has commenced on the draft changes - there are 5 specific areas to be agreed including TOIL which is currently in pilot stage.  120925 (TMM) T&F Group will be established to focus on this action however dates to be confirmed, this lines up with the resourcing policy action - <b>PROPOSE EXTENSION TO MARCH 26</b>
035-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	1.1d	The Trust should formally communicate to staff that the manner by which the diesel heaters can be re-started should the shoreline trip.	1.1d	Information will also be produced through the Workforce Education & Development Learn365 platform on the use of shorelines to ensure the topic is incorporated in training and education sessions.	Mar-25	Not Met	Apr-25	Nov-25		Closed in Quarter	25/26 Q2 Update: 031025 (AK): Since the Exposure to Fumes Audit was undertaken, the team has reflected on this recommendation and a great deal of work has been completed to ensure that the use of shorelines is incorporated in training and education sessions. As opposed to utilising the Learn365 platform, a classroom instruction package (shoreline tripping for diesel heater restart) has been delivered to all new or promoted staff accessing Driver Education since March 2024. <b>Proposed for closure.</b> The evidence supplied will mirror that already provided for Trust Ref 35-24/25
038-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	3.1	The Trust need to reiterate to staff the importance to following guidance to ensure their safety and lower their exposure to diesel fumes.	3.1	Mandatory safety notice to be distributed to all operational staff on the updated controls for fume mitigation and the importance of implementing them during delays at EDs, along with evidence that it has been read and understood.	Jan-25	Not Met	May-25	Sep-25		Closed in Quarter	25/26 Q2 Update: 150925 (AK): Proposed for closure. Evidence supplied: - Screenshot of confirmation page which must be ticked by the individual before they can complete the course - Confirmation (figures) of those who have completed the course via LMS365 - Screenshot of LMS365 Training Management Page for Shoreline and Bladeless Fan
040-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	3.1	To ensure completeness of such, the Trust should ensure that the systems currently used are designed to routinely capture the information required.	4.2	Where possible, any relevant data source will be automated for transfer into the Data Vault.	Mar-25	Not Met	May-25	Dec-25		Open	25/26 Q1 Update: 120625 (AK) Assistant Director of Digital Service: Data & Digital has advised that her team will be unable to progress this until at least July 2025. <b>Revised date of December 2025 proposed.</b>
044-24/25	2024/25	QuEST	Patient Experience & Community Involvement	Reasonable	Leanne Hawker	Liam Williams	Medium	3.1	The PECI team's work plan should be reviewed to better define and coordinate their activity.	1.1 (3)	PECI team to devise a proforma for directorates and quality improvement programmes/projects to request support and involvement to their scheme of work.	Apr-25	Not Met	TBA			Open	25/26 Q2 Update: 290925 (LT) Revised completion date to be advised following November 2025 QuEST meeting. Statement supplied by Executive Director of Quality and Nursing contained within Q2 Audit Reports to QuEST and ARAC.
045-24/25	2024/25	QuEST	Patient Experience & Community Involvement	Reasonable	Leanne Hawker	Liam Williams	Medium	3.1	The PECI team's work plan should be reviewed to better define and coordinate their activity.	1.1 (4)	PECI team to develop a population health-based approach to analysing interventions and involvement across Wales, enhancing reporting to inform where variation occurs and linking with Clinical and Quality teams to confirm how/where PECI team can support increased improvements in outcomes.	Aug-25	Not Met	TBA			Open	25/26 Q2 Update: 250925 (AK): This date will be revised pending the outcome of the revised PECI structure. Statement supplied by Executive Director of Quality and Nursing is reflected within the audit reports to QuEST and ARAC.
048-24/25	2024/25	QuEST	Patient Experience & Community Involvement	Reasonable	Leanne Hawker	Liam Williams	Medium	3.1	The Team should continue its work to increase survey responses to ensure there is significant level of response, to provide a level of assurance that responses reflect the views of the public.	3.1 (2)	Liaising with Fleet to explore use of QR Codes on vehicles to enable patients/families to access feedback surveys whilst waiting.	Mar-25	Not Met	Jul-25	Mar-26		Open	25/26 Q2 Update: 150925 (AK): Fleet Dept has requested that a paper be submitted to the Fleet SOP Delivery Group to gain formal approval and to be sighted on senior leadership support within the Quality, Safety & Patient Experience Directorate for this work. <b>Proposed revised date of March 2026</b> to take into account winter pressures.
053-24/25	2024/25	FPC	Vehicle Accident Management	Limited	Andrew Morgan	Chris Turley	Medium	1	<b>Vehicle Accident Investigation Guidance</b> The Trust does not have any guidance or checklists in place to support Line Managers when undertaking investigations into vehicle accidents.	1	The Trust will establish a Task and Finish Group with key stakeholders to review current processes, develop and support the implementation of guidance checklists for the Line Managers to consider when undertaking investigations.	Sep-25	Not Met	Dec-25			Open	25/26 Q2 Update: 221025 (LT) Insufficient evidence supplied to support proposed closure of action therefore action remains open with a 1st Revised Date of Dec25 applied.  260925 (TMM) A draft guidance document has been produced and will be going to SOT for discussion/approval on 7th October 2025. With the progress made on the guidance document and discussions no progressing for approval/implementation, copies of the triple A from the T&F group will be provided as evidence for this action. The T&F Group propose closure for this action.
054-24/25	2024/25	FPC	Vehicle Accident Management	Limited	Andrew Morgan	Chris Turley	Medium	2	<b>Driver Training Post Investigation</b> Where there is a need for drivers to undertake additional training post conclusion of the investigation, this is not formally documented by the line managers; or maintained within a central listing by the training department to demonstrate completion. This would allow analysis of themes and trends / repeat offenders to be identified.	2	The Trust will establish a Task and Finish Group (in line with key finding 1) with key stakeholders to review current processes and documentation that is in place, agree where the central listing of documentation will be held and how this will be managed and monitored.	Sep-25	Not Met	Dec-25			Open	25/26 Q2 Update: 221025 (LT) Insufficient evidence supplied to support proposed closure of action therefore action remains open with a 1st Revised Date of Dec25 applied.  260925 (TMM) The T&F group has reviewed the current processes that are in place and concluded that they are sufficient to the needs of reporting of investigations. The triple A outlines the rationale and the agreement in place for the Trust. The T&F Group propose closure for this action.
057-24/25	2024/25	FPC	Vehicle Accident Management	Limited	Andrew Morgan	Chris Turley	Medium	5	<b>Evidence of Third-Party Damage</b> Discussions held with the legal team noted that pictures are not routinely taken of the damage inflicted to third party property post an accident. This was further supported in our review of a sample of five legal claims where photographic evidence was not available.  Providing such would help the Trust in contesting claims received; and look to lower attributed costs if there was sight of the damage at the point of impact.	5	Ensuring that staff are properly trained and held accountable for reporting accidents is crucial. The Trust will establish a Task and Finish Group (same group as documented in Key Findings 1&2) with key stakeholders to review the audit recommendation and devise a communications strategy/training materials to be circulated to teams. This can be further enhanced/implemented via the local business meetings.	Sep-25	Not Met	Mar-26			Open	25/26 Q2 Update: 240925 (TMM) A bulletin is in the process of being created however with new regulations on photograph taken advised by legal team, further information is being sought from the Information Governance team before bulletin and training materials are finalised. The T&F Group propose an extension on this action to March 26 to allow time to gather accurate information and creation of bulletin and materials.
059-24/25	2024/25	QuEST	Roll-out of Pentrox	Reasonable	Judith Bryce / Huw Jackson	Andy Swinburn	Medium	1	<b>CFR Access to Replenish Pentrox Supply</b> Not all CFRs have access to either the Omnicell cabinets or the Pentrox Safes to replenish stock levels after use. To replenish the CFR requires a senior Trust employee (usually a DOM) to meet them at an Omnicell Cabinet or Pentrox safe to gain access and replenish supply.  Further, the Pentrox safes require Abloy keys to gain access. To date, only seven DOMs on the Abloy records have access.	1	CFR leads are required to confirm the names and PIN of all current CFRs, to allow the Medicines Management team to check them against those CFRs already on the Omnicell system.  North Wales Locality Managers to update the names and pay/ESR numbers of all DOMs that require access to the Pentrox safes. This will allow the Medicines Management team to check them against DOMs that already have the Pentrox access permission on their Abloy keys.	May-25	Not Met	Oct-25			Open	25/26 Q2 Update: 240925 (LJ) Update to be provided in October 2025 (Q3) as RO and workstream lead are on leave.

063-24/25	2024/25	PCC	Occupational Health & Wellbeing	Reasonable	Kim Crichton	Carl Kneeshaw	Medium	1	<p><b>Delivery of Wellbeing Strategy</b></p> <p>The Health &amp; Wellbeing Plan for 2025-29 was approved by Board in November 2024. It includes detail of deliverables, such as the development of a Trust's Health and Wellbeing Assessment Framework and outcomes.</p> <p>We note that the objectives remain the same as the previous plan and it is unclear the extent to which these have been achieved to date.</p> <p>From review of the document, the means by which the achievement of objectives will be measured and monitored were not identified, however we understand that local action plans are being developed to underpin the high-level outcomes set out within the Plan.</p>	1	<p>Full implementation and measurement plan to be finalised and agreed locally, reporting to the People and Culture Committee. The plan includes key deliverables, how they will be promoted and how effectiveness will be measured.</p> <p>This will consist of work programmes that are delivered by the Occupational Health &amp; Wellbeing service alongside broader work programmes that are not exclusively delivered by the service.</p>	Mar-25	Not Met	Oct-25		Closed in Quarter	<p><a href="#">25/26 Q2 Update:</a></p> <p>250925 (KC): Delivery plan developed, progress is being monitored via Health &amp; Wellbeing Steering Group. Propose to close. Evidence supplied to support closure: HWP Delivery Plan Sept 2025.</p>
064-24/25	2024/25	PCC	Occupational Health & Wellbeing	Reasonable	Kim Crichton	Carl Kneeshaw	Medium	2	<p><b>Enhance Occupational Health Performance Data</b></p> <p>Whilst the All Wales KPIs are monitored, further information is available within the occupational health referral system that could be analysed to enhance performance reporting.</p>	2	<p>Occupational Health will conduct a comprehensive review of available data within OPAS G2 to identify additional performance indicators that can enrich our reporting processes, alongside the All Wales KPIs. This will include monitoring areas such as needlestick injuries, immunisation reviews, and other relevant clinical activities. A robust process will be established to regularly analyse and report on these indicators to support service improvement and trend identification.</p>	May-25	Not Met	Sep-25	Sep-26	Open	<p><a href="#">25/26 Q2 Update:</a></p> <p>131125 (LT) Update from CK in PCC - 2nd revised date amended from Mar/26 to Sep/26 as this relates to all All Wales issue with the supplier (Cvica). The team need to consult with the national group to understand the outcome on a system level. If there are no concrete timeframes yet, we can plan to implement a local workaround.</p> <p>221025 (LT) 2ns Revised Date (Mar/26) therefore Director of People to be asked to attend ARAC to provide update and assurance.</p> <p>250925 (KC): The enhanced Occupational Health &amp; Wellbeing report has been implemented for monthly monitoring of service KPIs. However the reporting system is experiencing technical issues that currently prevent full extraction of data required for the KPI report. A partial report is available, however does not fully capture all the KPIs. Technical issues has been reported to CVCA to fix and awaiting resolution which may take up to 6 months. <b>Propose revised deadline to Mar-26.</b></p>
065-24/25	2024/25	PCC	Occupational Health & Wellbeing	Reasonable	Kim Crichton	Carl Kneeshaw	Medium	3	<p><b>Trend Analysis to Focus Service Provision and Resources</b> Occupational Health do not run routine reports to identify services with high absence rates or referral themes that could be used to focus resources proactively.</p>	3	<p>Occupational Health will develop and implement additional internal reporting process within the Occupational Health system OPAS G2; to identify key themes and trends from referrals, such as common reasons for referral, health conditions or patterns linked to specific service areas or staff groups. These reports will be used to highlight emerging issues and identify areas where proactive support or targeted interventions may be required.</p> <p>Occupational Health will work with People Services and the wider People and Culture directorate to agree how key information can be shared at an organisational level to support wider workforce planning and potential wellbeing initiatives.</p>	Jul-25	Not Met	Sep-26		Open	<p><a href="#">25/26 Q2 Update:</a></p> <p>131125 (LT) Update from CK in PCC - 2nd revised date amended from Mar/26 to Sep/26 as this relates to an All Wales issue with the supplier (Cvica). The team need to consult with the national group to understand the outcome on a system level. If there are no concrete timeframes yet, we can plan to implement a local workaround.</p> <p>250925 (KC): There is a plan to initiate regular meetings between the new Head of People and the OH Manager, in order to review key themes and trends recognised within Occupational Health referrals and support. However, these are yet to be established due to the unresolved reporting and dashboard issues causing a delay in progressing this action, as outlined in the above action. <b>Propose revised deadline of Mar/26.</b></p>
066-24/25	2024/25	PCC	Occupational Health & Wellbeing	Reasonable	Kim Crichton	Carl Kneeshaw	Medium	4	<p><b>Evaluation of Service Quality and Outcome Measures</b></p> <p>Although we note that a range of early interventions have been implemented within the Trust, there has been limited evaluation data. The Service is working hard to be proactive and is reaching out to managers. However, there is a need to improve the arrangements in place, to demonstrate the quality of the service and outcome measures, to demonstrate the value of the interventions the Trust has invested in. This could include deep dive exercises into those introduced to support the main causes of sickness absence, to further inform and tailor the development of the same.</p>	4	<p>The Occupational Health &amp; Wellbeing service will establish routine reporting systems to track the effectiveness of the programmes implemented.</p> <p>Wellbeing practitioner support, TRIM, REACT, EAP, Physio, Manager consultation outcomes will be routinely reported via both patient-reported experience measures (PREMs) and patient reported outcome measures (PROMs) to ensure that they are delivering for our staff. It is noted that the effectiveness of these interventions will vary and therefore routine reporting is necessary to assess these trends.</p> <p>For example, TRIM will report access rates, number of staff engaging in follow-up, number of staff requiring further support and the destination of support (e.g. EAP). Furthermore, the user experience of TRIM will be routinely reported.</p>	Mar-25	Not Met	Jul-25		Closed in Quarter	<p><a href="#">25/26 Q2 Update:</a></p> <p>250925 (KC) Evaluation of data shows increased feedback response rates since transitioning to MS Forms, which is now fully anonymised. QR codes are available for staff to provide feedback, in addition to email links being shared; the use of text messages is also being considered to improve accessibility for staff. The new TRIM app will feature dashboards designed to facilitate monthly data collection and the evaluation of emerging themes and trends. <b>Propose to close.</b></p> <p>Evidence supplied to support closure: Routine measures of quantitative measures in the form of Wellbeing Service Data Presentation for 3mths (Jun/25, Jul/25 &amp; Aug/25).</p>
067-24/25	2024/25	FPC	Estates Assurance - Energy Management	Substantial	Head of Estates	Chris Turley	Medium	1	<p>35% of sampled readings were estimated.</p> <p>Although it was noted that these were appropriately chased with 71% of them being submitted within a month, this also represented a risk that invoices may be issued by the energy provider for incorrect values affecting the timing of the cashflow of the Trust.</p> <p>The Trust has advised that: "Monthly updates via WEOG meetings with the energy provider include smart meter/AMR rollout update.</p> <p>WAST are a member of WEOG and participate actively with this meeting. The trusts previous Environment and Sustainability Manager was also in contact with the energy provider's booking team to facilitate progress of this roll out.</p> <p>It however must be noted that WAST has no control over the speed and efficiency of the energy provider's smart meter roll out and can only raise as a concern at WEOG meetings. As there is a procedure in place to ensure that invoices are adjusted to actual reads in a timely manner, therefore the impact on Trust cashflow should be virtually insignificant."</p>	1	<p>The new Environment and Sustainability Manager, in post March 2025 will be an active participant of WEOG and will endeavour to progress roll out at a quicker pace.</p> <p>NB: Target Implementation Date = 30th June 2025 Please note this is the implementation date of the new manager attending WEOG and not installation of a Trust-wide AMR-Smart meter project, WAST has little control on that timescale.</p>	Jun-25	Not Met	Sep-25		Closed in Quarter	<p><a href="#">25/26 Q2 Update:</a></p> <p>131025 (JH): Proposed for closure. Email dated 13/10/25 from Richard Davies providing evidence to support closure including Minutes of WEOG Meetings, and copy of email progressing smart meter installation.</p>
068-24/25	2024/25	FPC	Estates Assurance - Energy Management	Substantial	Head of Estates	Chris Turley	Medium	2	<p>Educational media created by the WAST to encourage behaviours conducive to good energy management, were not displayed in estate premises sampled.</p> <p>The Trust have advised: "The new Environment and Sustainability Manager starting March 2025, will be tasked with updating current training materials, plus communication materials to encourage reduced use of energy, this will be supported by WAST communications team.</p> <p>As the new manager starts in post March 2025 and requires bedding in time, plus the imminent ISO14001 internal audit requirements, this will be scheduled in for an appropriate time."</p>	2	<p>Handover meeting between previous environment and sustainability manager and new environment and sustainability manager booked for 18th March. This handover will include the requirement to address training concerns, and to allow time to develop a comms plan at an appropriate juncture.</p>	Sep-25	Met			Closed in Quarter	<p><a href="#">25/26 Q2 Update:</a></p> <p>131025 (JH): Proposed for closure. Email dated 13/10/25 from Richard Davies providing evidence to support closure including copy of email and details of WAST Account Issues EDF (v72) - eef updates.</p>

069-24/25	2024/25	FPC	Estates Assurance - Energy Management	Substantial	Head of Estates	Chris Turley	Medium	3	<p>On an uncomplicated single invoice and payment scenario, whilst the payment was not delayed, this had resulted in 9 emails and 8 separate email addresses.</p> <p>A strategy should be considered to use a system driven approach to managing invoicing which would allow an invoice to be more easily matched and coded to the correct Trust and distributions on Oracle and would allow for approvals to be facilitated via a system approval hierarchy linked to the Trust's Scheme of Delegation.</p>	3	We will review the current energy invoice receipt, approval and payment processing arrangements with a view to streamline current arrangements maximise efficiency.	Jun-25	Not Met	Sep-25			Closed in Quarter	<p><a href="#">25/26 O2 Update:</a> 131025 (HJ): Proposed closure of action. Email dated 13/10/25 from Richard Davies supplying evidence to support closure including: Email outlining current EDF portal and invoice monitoring and approval process, confirmation that issues have decreased significantly but not yet in position to move to consolidated billing.</p>
070-24/25	2024/25	PCC	Speaking Up Safely	Reasonable	Speak Up Safely Lead Guardian	Angela Lewis	Medium	1	<p>Although we can evidence that progress against the requirements of the Framework has been made there are still areas, from both the October 2023 and, more latterly, the November 2024 self-assessments which require development. There will also be some actions for consideration from the findings at this Internal Audit report.</p> <p>However, there is no action plan in place to support the detail of the work, assigned responsibility and expected timeline.</p> <p>Regular reporting of the actions, to an appropriate forum, would facilitate monitoring of progress of implementation.</p> <p><b>Risk &amp; Impact:</b> Reduced accountability and evaluation of goals which may lead to missed deadlines.</p>	1	<p>We responded in detail to the request from Welsh Government to assess ourselves against the requirements of the framework in October 2023 and November 2024 and used this to plan our actions including the introduction of the lead Guardian.</p> <p><b>Agreed Action:</b> We will transfer outstanding actions into an action plan format.</p> <p><b>Expected Evidence of Implementation:</b> Action plan and governance route.</p>	Sep-25	Met			Closed in Quarter	<p><a href="#">25/26 O2 Update:</a> 180925 (LOS) Action Plan has been developed, with progress monitored via the Speaking Up Safely Team. Propose to close action. Evidence supplied to support closure of action.</p>	
071-24/25	2024/25	PCC	Speaking Up Safely	Reasonable	Speak Up Safely Lead Guardian	Angela Lewis	Medium	2	<p>Surveys are not consistently being issued following closure of SUS cases on the WIC platform thereby reducing the ability to obtain meaningful feedback into the management and outcome of the case. There is also further work required regarding lessons learnt and feedback loops to demonstrate actions taken by the Trust post 'speaking up', and also how detriment is managed.</p> <p><b>Risk &amp; Impact:</b>Reduced opportunities to learn from lessons.</p>	2.1	<p>Progress continues to be made, and surveys have been routinely sent automatically from WIC since its introduction on closure of a conversation.</p> <p>The Guardian also sends a questionnaire on closure of all other cases that are reported to the Guardian via email, call or in person. The Director of Culture Change flagged that we were exploring how to address detriment and as such it falls outside the remit of this audit. However, we have carried out initial research and put support in place for those who have experienced detriment.</p> <p><b>Agreed Action:</b> Lessons learnt meetings regularly scheduled to review cases across key professions (Surveys and lessons meetings in place).</p> <p><b>Expected Evidence of Implementation:</b> Routine recording that questionnaires have been sent. Meetings scheduled and lessons learnt collated and shared in an appropriate forum. Risk Assessment framework.</p>	Sep-25	Met			Closed in Quarter	<p><a href="#">25/26 O2 Update:</a> 180925 (LOS) Questionnaires post closure are routinely issued to individuals raising concerns, albeit the response rate is currently very low. Further work to encourage individuals to provide feedback is to be prioritised.</p> <p>Lesson learnt meetings will reconvene in September/early October 2025.</p> <p>Individual Risk Assessment developed and agreed ready for use. Propose to close. Evidence supplied to support closure.</p>	
072-24/25	2024/25	PCC	Speaking Up Safely	Reasonable	Speak Up Safely Lead Guardian	Angela Lewis	Medium	2	<p>Surveys are not consistently being issued following closure of SUS cases on the WIC platform thereby reducing the ability to obtain meaningful feedback into the management and outcome of the case. There is also further work required regarding lessons learnt and feedback loops to demonstrate actions taken by the Trust post 'speaking up', and also how detriment is managed.</p> <p><b>Risk &amp; Impact:</b>Reduced opportunities to learn from lessons.</p>	2.2	<p>Progress continues to be made, and surveys have been routinely sent automatically from WIC since its introduction on closure of a conversation.</p> <p>The Guardian also sends a questionnaire on closure of all other cases that are reported to the Guardian via email, call or in person. The Director of Culture Change flagged that we were exploring how to address detriment and as such it falls outside the remit of this audit. However, we have carried out initial research and put support in place for those who have experienced detriment.</p> <p><b>Agreed Action:</b> Develop risk assessment framework to mitigate potential detriment (sharing of lessons learned process)</p> <p><b>Expected Evidence of Implementation:</b> - Routine recording that questionnaires have been sent. - Meetings scheduled and lessons learnt collated and shared in an appropriate forum. - Risk Assessment framework.</p>	Mar-26	Not Yet Due			Open	<p><a href="#">25/26 O2 Update:</a> 180925 (LOS) Management Essentials continues to be rolled out within the organisation, including section on SUS.</p> <p>Awareness of Speaking Up Safely process to be emphasised during Speaking Up Safely month, in October 2025.</p>	
073-24/25	2024/25	PCC	Speaking Up Safely	Reasonable	Speak Up Safely Lead Guardian	Angela Lewis	Medium	3	<p>As has already been recognised, more work is required to embed the requirements of the national SUS Framework within the training offerings.</p> <p>The need for further training on the internal processes available has been identified to ensure the correct and timely direction for the concern/issue raised at the Trust; in addition to clarity in the People and Culture Directorate of roles and responsibilities as well as those of the line managers.</p> <p>There is a need to manage the broader education, at a local level, of the positive nature of Speaking Up in the workplace and to minimise the fear of alienation / retribution.</p>	3	<p>The people and culture plan aspires to cultivate a culture of psychological safety and while training on the speak up process is helpful, dialogue and awareness raising is our preferred medium.</p> <p><b>Agreed Action:</b> - Formal plan to raise awareness of Speaking Up Safely process that encourages reporting through appropriate channels. - Signposting to SUS training included in Manager's Essentials. - Collaboration across People and Culture directorate to work more closely and understand each other's roles. - Continued culture work to increase psychological safety.</p> <p><b>Expected Evidence of Implementation:</b> - Record of numbers of people completing training. - Awareness raising and engagement plan. - Support for those who speak up including clinical psychology support in line with recommendations from NGO. - People and Culture Plan milestones. - Weekly meetings with deputy head of people services and Guardian (in place).</p>	Mar-26	Not Yet Due			Open	<p><a href="#">25/26 O2 Update:</a> 180925 (LOS) Management Essentials continues to be rolled out within the organisation, including section on SUS.</p> <p>Awareness of Speaking Up Safely process to be emphasised during Speaking Up Safely month, in October 2025.</p>	

074-24/25	2024/25	PCC	Speaking Up Safety	Reasonable	Speak Up Safety Lead Guardian	Angela Lewis	Medium	4	<p>The functionality and capability of the WIC platform is currently not being maximised by the Trust. There is a lack of recording across all available fields, including key elements of the framework, such as to capture key timescales (date received, date acknowledged, followed up every 14 days, date outcome communicated), outcome of concern, and to better understand the reason for raising via the WIC platform. All of which would improve the triangulation of data in relation to SUS.</p> <p>The same is applicable to the records that are maintained by the Guardian for those cases received directly.</p> <p>We note that the Q3 report to the Chief Executive, Non-Executive Director (SUS Champion), Director of Culture Change has been updated to incorporate reporting on timelines but such is limited to the most serious ongoing cases from that quarter (3 cases).</p> <p>Further, whilst the report provides a status update of cases, it is only in relation to those raised within that given period rather than a cumulative position.</p> <p>There is a lack of reporting and analysis of the above, including compliance with timescales, both locally and to Board-level committee.</p> <p><b>Risk &amp; Impact:</b> Limited assurances in respect of wider concerns and Speaking Up Safety cases. Timelines for dealing with cases may be protracted leading to detriment.</p>	4	<p>The lead guardian maintains an excel database that includes all cases reported to the Guardian via the four routes in scope – email, call, in person, WIC. All the information outlined in the findings (4) is recorded there and has been since the start of Q4. WIC routinely records the data outlined for all conversations raised via that platform. We are working with WIC to include the additional information the Guardian holds on their database to streamline and automate reporting, this relates to demographic data that will be reported once there is sufficient to ensure those who have spoken up are not identifiable.</p> <p><b>Agreed Action:</b> Work with WIC so that their product can replicate the Guardian's database to reduce data management time in producing reports. Routine reporting of timescales in quarterly reports.</p> <p><b>Expected Evidence of Implementation:</b> Reports at appropriate meetings on time with robust confidential data.</p>	Oct-25	Not Yet Due			Open	<p><a href="#">25/26 Q2 Update:</a> 180925 (LOS) Work continues in respect of WIC reporting and the exploration of the platform reporting mechanisms for robust confidential data. Reports from the WIC system were however used to produce data for both Q1 and Annual Speaking Up Safety reports.</p>
075-24/25	2024/25	PCC	Speaking Up Safety	Reasonable	Speak Up Safety Lead Guardian	Angela Lewis	High	5	<p>The SUS Framework defines data points for recording and monitoring individual concerns through the triangulation of lessons learned from closed concerns and the communication of outcomes. However, currently information on all concerns raised through various sources is not collated or reported into a collective document or report for management therefore making it difficult to identify themes or trends and feed learning back to directorates.</p> <p><b>Risk &amp; Impact:</b> Speaking Up Safety cases.</p>	5	<p>Safety team, safeguarding, clinical concerns, people services, the EDI team, or highly confidential Data in our reporting. However we meet with these teams in lessons learned forums to discuss and notice themes.</p> <p>We also feel it's important to highlight that it is important not to lose sight of the individuals accessing our services and the culture we wish to create, in the pursuit of data for reporting purposes.</p> <p>Given the relatively small numbers of SUS concerns in relation to numbers of people in directorates we are cautious about committing to reporting back directorate themes given increasing any fear of identification; inadvertently silencing people. Detriment is something we are trying to mitigate against and this is one area that can support that mitigation. This is certainly something that we could review once we have more years of data to share.</p> <p><b>Agreed Action:</b> Share themes in reporting to CEO, Board champion and Directors of Culture Change and People (in place).</p> <p>Share themes in lessons learned forums and in discussion of people and culture themes and trends paper (in place).</p> <p><b>Expected Evidence of Implementation:</b> Discussion at lessons learned forums and in reporting to CEO.</p>	May-25	Not Met	Oct-25		Open	<p><a href="#">25/26 Q2 Update:</a> 180925 (LOS) Monthly confidential meeting with Lead Guardian and CEO remains in place. Meeting with Board Champion along with Directors of Culture Change and People also convened during Q2. Key themes highlighted.</p>
076-24/25	2024/25	PCC	Speaking Up Safety	Reasonable	Speak Up Safety Lead Guardian	Angela Lewis	Medium	6	<p>Whilst high level analysis of SUS cases is reported to PCC, and incorporated into the AAA report to ARAC as appropriate, there has been no annual report submitted to ARAC in line with expectation.</p> <p><b>Risk &amp; Impact:</b> Limited assurances in respect of Speaking Up Safety cases.</p>	6	<p>The lead Guardian has been in post less than a year and the annual report is due to go to ARAC in June 2025. The Trust Board has received a six-monthly report at its meeting on 27 March 2025.</p> <p><b>Agreed Action:</b> Annual report to ARAC.</p> <p><b>Expected Evidence of Implementation:</b> Report to ARAC.</p>	Jun-25	Not Met	Oct-25		Open	<p><a href="#">25/26 Q2 Update:</a> 220925 (SP) Speaking Up Safety Annual Report presented to People and Culture Committee in August 2025. Report to proceed to ARAC on 2nd September 2025 and Trust Board on 25th September. Propose to close. Evidence supplied to support proposed closure.</p>
077-24/25	2024/25	QuEST	Risk Management & Board Assurance Framework	Reasonable	Julie Boalch	Trish Mills	Medium	1	<p>The current documented guidance is sufficient to cover the existing approach to risk management across the Trust but in the light of the planned developments for the BAF, risk appetite, and the potential procurement of a digital solution, the procedures will need to be revised, updated and appropriately approved.</p> <p><b>Risk &amp; Impact:</b> The documented guidance may become out of date as procedures change, leading to risks not being managed as intended.</p>	1	<p>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 reaproved.</p> <p><b>Expected Evidence of Implementation:</b> Updated suite of Risk Management documentation.</p>	Mar-26	Not Yet Due			Open	-
079-24/25	2024/25	QuEST	Emergency Communication Nurse System (ECNS) Implementation	Reasonable	Jonathan Edwards	Lee Brooks	High	2	<p><b>ECNS Audit Arrangements</b> Capacity constraints within the PPE team (currently 2.8WTE) has resulted in delays in completion, with December 2024 audits still to be completed as at April 2025, resulting in a backlog in excess of 400 audits.</p> <p>The need to review the operational capacity of the PPE team has been recognised by Integrated Care management, and a business case to secure dedicated ECNS auditors within an Operations Quality team (within the Emergency Medical Service Co-ordination structure) has been approved, although a timescale of implementation was not available at time of audit fieldwork.</p> <p><b>Theme:</b> Resourcing</p> <p><b>Risk &amp; Impact:</b> Continued lack of capacity to deliver audits could result in loss of accreditation.</p>	2	<p><b>Agreed Action:</b> The Trust will have the uplifted number of 6 ECNS auditors in place in Q2 of 25/26 financial year. This uplift will be commensurate with the levels agreed in the business case.</p>	Sep-25	Met			Closed in Quarter	<p><a href="#">25/26 Q2 Update:</a> 120925 (TMM) The Operations Quality OCP: Operations Quality OCP consultation period finished on 05 Sept and the final consultation document will be released this week. Implementation phase commences on 22 September 2025. The Quality Audit (Clinical) JD has been matched and CAJE'd and recruitment can begin end of Sept 2025. PROPOSE CLOSURE</p>

080-24/25	2024/25	QuEST	Emergency Communication Nurse System (ECNS) Implementation	Reasonable	Andrew Garner	Lee Brooks	Medium	3	<p><b>ECNS Audit Report Format</b></p> <p>Review of audit reports confirmed that they provided a mix of recognition of good practice alongside areas where corrective feedback was required. IAED performance standards notes that when providing feedback there should be focus on the exact performance that did not meet the standard.</p> <p>Our review of 30 audit reports noted that 13 did not reference the performance standard where an issue had been identified, and 17 did not indicate the categorisation of deviation.</p> <p>Currently audit reports are circulated via email to the clinician and line manager, however, there is no requirement for receipt or acknowledgement of content.</p> <p><b>Theme:</b> Performance Monitoring</p> <p><b>Risk &amp; Impact:</b> Unclear and delayed feedback impact on the value and ability to influence practice of audits.</p>	3	<p><b>Agreed Action:</b> Quality Audit realigned to Operations Quality and bespoke job description being created to appoint into permanent Quality Audit (Clinical) posts. Operations Quality to have management and leadership oversight. Levelling to be undertaken to set out expectations for inclusion of all required information such as performance standards and deviation categories and a request to support levelling will be made to the International Academies of Emergency Dispatch (IAED).</p> <p>Consideration will be given more widely on how to ensure monitoring of receipt of feedback and respective managers/local management teams updated.</p> <p><b>Expected Evidence of Implementation:</b> Quality assurance processes will be developed and refined internally, and the IAED Accredited Centre of Excellence (for which the Trust has for ECNS) sets out required standards which will be monitored closely in monthly compliance reports, submitted to the IAED and internally monitored by the Integrated Care Quality Meeting which reports onward into the Senior Operations Team (SOT).</p>	Dec-25	Not Yet Due				Open	<p><a href="#">25/26 Q2 Update:</a></p> <p>290925 (TMM) Forms part of the Operations Quality OCP and recruitment will begin shortly now this has been completed. Operations Quality will work with Integrated Care and the IAED to refine and agree processes and providing assurances in the Integrated Care Quality Meeting. Reports will be developed and refined once this team is in place to ensure operational teams are receiving the required information and assurance on quality monitoring. On track for December, however, will be evolving over time.</p>
081-24/25	2024/25	QuEST	Emergency Communication Nurse System (ECNS) Implementation	Reasonable	Peter Brown	Lee Brooks	High	4	<p><b>ECNS Monitoring Arrangements</b></p> <p>The QAF and IAED performance standards include the need for ongoing monitoring of individual clinician performance on a routine basis. A locally held spreadsheet has been developed to support this due to constraints within the AQUA reporting tool and need for cleansing of prior user data.</p> <p>Inconsistencies were noted when comparing this spreadsheet to AQUA generated reports regarding the clinicians included (10 identified as receiving audits but not detailed within the spreadsheet) and the number of audits recorded (only one out of six months totalling the required 132 audits).</p> <p>Additionally, we identified:</p> <ul style="list-style-type: none"> <li>- six clinicians yet to receive audits, and</li> <li>- on average, 44% of CSD clinicians did not receive an audit each month within our sample period June 2024 – November 2024.</li> </ul> <p><b>Theme:</b> Performance Monitoring</p> <p><b>Risk &amp; Impact:</b> Control Operation</p>	4	<p><b>Agreed Action:</b> A review will be conducted to move to a single monitoring mechanism with appropriate data cleansing processes. The reporting mechanism will be embedded into Integrated Care Quality Meeting (ICQM) and through the Senior Ops Governance Structure along with CQGG. Those not in receipt of an audit are being prioritised.</p> <p><b>Expected Evidence of Implementation:</b> AQUA Reporting will be the primary methodology used to report compliance.</p>	Sep-25	Met				Closed in Quarter	<p><a href="#">25/26 Q2 Update:</a></p> <p>120925 (TMM) A review has been conducted to transition to a single monitoring mechanism for ECNS, with AQUA system data now established as the sole source. Appropriate data cleansing processes have been embedded, including regular updates via PPD meetings and improved communication with the integrated care management team. The reporting mechanism is now formally embedded into the Integrated Care Quality Meeting, ensuring ongoing oversight and accountability.</p> <p><b>PROPOSED CLOSURE.</b> Evidence supplied: IC Quality Assurance AAA 21.08.25 v1</p>
082-24/25	2024/25	QuEST	Emergency Communication Nurse System (ECNS) Implementation	Reasonable	Jonathan Edwards	Lee Brooks	Medium	5	<p><b>ECNS Performance Development Plans</b></p> <p>Where a clinician is identified as 'below a performance threshold' the QAF outlines a performance development plan (PDP) structure to be applied to offer action plans which include additional support, enhanced audits and further escalation where improvement is not achieved.</p> <p>At present, due to the lack of capacity within the PPE team to undertake additional audits, the PDP process is not actively practiced. However, we were advised that local management will engage with ECNS users on wider performance issues. The limitations in coverage and number of clinicians receiving regular audits (see key finding 4) also impacts the effectiveness of the PDP process in identifying those who require additional support.</p> <p><b>Theme:</b> Performance Monitoring</p> <p><b>Risk &amp; Impact:</b> Lack of mechanisms to address continued non-compliance</p>	5	<p><b>Agreed Action:</b> As per the agreed action for Key Finding 2 the Trust will have the uplifted number of ECNS auditors in place in Q2 of 25/26 financial year. This uplift will be commensurate with the levels agreed in the business case. This will enable the required levels of audits.</p> <p><b>Expected Evidence of Implementation:</b> The uplifted levels will be evidenced through establishment reports.</p>	Sep-25	Met				Closed in Quarter	<p><a href="#">25/26 Q2 Update:</a></p> <p>120925 (TMM) The Operations Quality OCP: Operations Quality OCP consultation period finished on 05 Sept and the final consultation document will be released this week. Implementation phase commences on 22/09/2025. The Quality Audit (Clinical) ID has been matched and CAVE'd and recruitment can begin end of Sept 2025.</p> <p><b>PROPOSED CLOSURE</b></p>
083-24/25	2024/25	QuEST	Emergency Communication Nurse System (ECNS) Implementation	Reasonable	Mike Brady	Lee Brooks	Medium	6	<p><b>Periodic Benefit Assessment</b></p> <p>We could not identify any post implementation review, or subsequent assessment of the system benefits since the closure of the project. As such the Trust will not be sighted on the system impacts, outcomes and progress towards benefit realisation.</p>	6	<p><b>Agreed Action:</b> The Trust accepts this finding and agrees with the necessity for clearer benefits assessment milestones at the beginning of such programmes. The majority of benefits were, however, fully realised upon implementation. Consequently, ongoing periodic benefits assessments were not planned. The later rapid addition of 28 full-time clinicians, while helpful, shifted focus and changed baseline operational benefits of other metrics, due to new and rotating CSD staff and demand-capacity adjustments.</p> <p>Operational measures are now monitored through existing mechanisms.</p> <p>The Trust will develop a clear table of evidence outlining which benefits have been achieved on implementation (how and why) and which outstanding benefits require more work or are not being monitored through existing mechanisms or link to existing agreed actions within this audit.</p> <p><b>Expected Evidence of Implementation:</b> Development of a table of ECNS benefits with outline of evidence or monitoring.</p>	Sep-25	Met				Closed in Quarter	<p><a href="#">25/26 Q2 Update:</a></p> <p>120925 (TMM) Following on from a meeting with Audit Wales, work has been undertaken with the team to produce a draft table to receive feedback comments on the proposed benefits. This version of the draft is being submitted internally for review.</p> <p><b>Propose Closure.</b></p>

087-24/25	2024/25	FPC	Forecasting & Modelling	Reasonable	Hugh Bennett	Rachel Marsh	Medium	1	<p><b>Modelling and Forecasting Process</b></p> <p>Through discussion, it is evident that while forecasting and modelling activity is clearly embedded within the Trust, the process lacks sufficient documentation and clarity of the arrangements. The following weaknesses were identified:</p> <ul style="list-style-type: none"> <li>-There is no mechanism that captures the business-critical models or forecasts that the Trust applies, to clarify ownership and track key stages of the process, e.g. approvals, evaluation undertaken, version control, etc. We note that the winter plan was discussed at Operations Directorate Senior Leadership Team meeting, but there is no record of its approval.</li> <li>-The work of the external consultants engaged for forecasting and modelling activities is subject to their own internal checks. The quality assurance reviews of the work performed within the Trust have only recently been initiated but cannot be consistently evidenced (we saw evidence within the EMS Operational Transformation Closure report).</li> <li>-One of the key responsibilities of the Forecasting and Modelling Group (as detailed in its terms of reference) is to obtain user feedback, but this is not clearly recorded within the process (although evidence was supplied of this for the Easter 2025 111 rostering).</li> <li>-There has been no comprehensive assessment or evaluation of the Trust's forecasting and modelling activities, including its alignment to key priorities. This would be beneficial for effectively managing staff resource and ensuring alignment with organisational goals.</li> </ul> <p><b>Theme:</b> Information, Data Quality &amp; Data Accuracy</p> <p><b>Risk &amp; Impact:</b> Ineffective arrangements resulting in wasted resources and a failure to plan effectively resulting in poorly designed services.</p>	1	<p><b>Agreed Action:</b> Complete the draft Standard Operating Procedure for Forecasting &amp; Modelling. This would include approvals, version control and evaluations. Develop a forecasting &amp; modelling report tracker, which would enable the Forecasting &amp; Modelling Group to track where reports go, who uses them, user feedback, lessons learnt and benefits; and evidence of quality assurance (where appropriate). The Forecasting &amp; Modelling Group will undertake a formal review of the draft IMTP from a forecasting and modelling perspective to ensure that its work programme reflects the IMTP priorities.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- Standard Operating Procedure and Forecasting &amp; Modelling Report Tracker included in AAA (Alert, Advise, Assure) report to Strategy, Planning &amp; Performance Directorate Business Leadership Team meeting;</li> <li>- formal review of IMTP from a forecasting and modelling perspective to go to integrated Technical Planning Group and noted in AAA reporting up to Strategic Transformation Board.</li> </ul>	Mar-26	Not Yet Due				Open
088-24/25	2024/25	FPC	Forecasting & Modelling	Reasonable	Hugh Bennett	Rachel Marsh	Medium	2	<p><b>Documented Procedures</b></p> <p>There is a small team responsible for carrying out forecasting and modelling activity within the Trust, consisting of a Senior Commissioning &amp; Performance Analyst (within the Strategy, Planning &amp; Performance Directorate) who is principally involved in modelling processes; and a Principal Analyst (Operations Directorate) who carries out forecasting work. However, there are no documented procedures to provide clarity and ensure consistency of approach.</p> <p>An initial version of a Standard Operating Procedure (SOP) has been developed to outline the Trust's structures and processes for the management of Onda Optima Predict (an externally provided software designed for testing hypotheses and scenarios). However, there is no documented guidance or templates to clearly detail roles and responsibilities (both internal and external) and clarifies the process for strategic, operational and tactical forecasting and modelling.</p> <p>Although forecasting processes are predominantly automated, not all the key staff that carry out forecasting and modelling activity have the same level of access to data, e.g. to a 'warehouse' to source key data independently. Capacity also needs to be considered for the management of the process including carrying out quality assurance checks and the development of supporting procedures. While we were advised that the Digital Service Directorate and external consultants could provide forecasting and modelling resource in the absence of key staff, business continuity arrangements would benefit from a review to ensure the processes in place are robust to enhance resilience.</p> <p><b>Theme:</b> Policies &amp; Procedures</p> <p><b>Risk &amp; Impact:</b> Inconsistent processes leading to a lack of accountability and oversight.</p>	2	<p><b>Agreed Action:</b> Complete the draft Standard Operating Procedure for Forecasting &amp; Modelling. This would include approvals, version control, access to data and evaluations. The Executive Director of Strategy, Planning &amp; Performance and Assistant Director Commissioning &amp; Performance are currently reviewing the capacity of the Commissioning &amp; Performance Team, of which forecasting and modelling is a part. As part of this review, we will consider business continuity for forecasting and modelling in the Trust.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- Standard Operating Procedure shown in AAA report to Strategy, Planning &amp; Performance Directorate Business Leadership Team meeting;</li> <li>- review of Commissioning &amp; Performance Team's capacity / structure confirmed via Director.</li> </ul>	Nov-25	Not Yet Due				Open
089-24/25	2024/25	FPC	Forecasting & Modelling	Reasonable	Rachel Marsh & Hugh Bennett	Rachel Marsh	Medium	3	<p><b>Terms of Reference</b></p> <p>The latest version of the Forecasting and Modelling Group's terms of reference (ToR) was provided, but the following weaknesses were identified:</p> <ul style="list-style-type: none"> <li>- Frequency of review: The ToR was approved by the Executive Director of Strategy, Planning &amp; Performance in April 2024, but the document does not record how frequently it should be reviewed noting that good practice is that such documents should undergo a review at least annually.</li> <li>- Responsibilities: The content of the ToR needs to be updated to reflect the current position as it details that one of the Group's responsibilities is to develop and maintain the Trust's Forecasting and Modelling Framework. This has been de-prioritised due to limited staff capacity and other priorities.</li> <li>- Membership: Similarly, we were advised that the current membership of the Group is not reflective of that detailed in the ToR.</li> <li>- Escalation arrangements: The ToR does not detail escalation arrangements. Reporting arrangements are noted as the Group will report to the Executive Director of Strategy, Planning &amp; Performance, who is the Executive Sponsor and that she will attend the Group once a year. Due to other priorities, she has been unable to attend as required.</li> </ul> <p><b>Theme:</b> Governance</p> <p><b>Risk &amp; Impact:</b> Unclear roles and responsibilities leading to a lack of accountability and failure to deliver key priorities.</p>	3	<p><b>Agreed Action:</b> Undertake annual review of terms of reference.</p> <p><b>Expected Evidence of Implementation:</b> Updated ToR, approved in Strategy, Planning &amp; Performance Directorate Business Leadership Team meeting.</p>	Sep-25	Met			Closed in Quarter	25/26 D2 Update: 240925 (HB) - Reviewed at F&M Group in August 2025 and subsequently signed off by the Exec Sponsor, Rachel Marsh.

090-24/25	2024/25	FPC	Forecasting & Modelling	Reasonable	Hugh Bennett	Rachel Marsh	Medium	4	<p><b>Winter Resilience Planning</b></p> <p>The following weaknesses were identified in the winter planning process:</p> <ul style="list-style-type: none"> <li>- While the Winter Modelling (2024/25) provides a comprehensive overview of data limitations, the data assumptions are not recorded, e.g. average time in hospital.</li> <li>- Consideration was not given to the Welsh Government's (WG) 2024/25 Winter Modelling scenario planning (September 2024) when developing the Trust's exercise. The WG's report provides retrospective analysis, comparing actual performance against the winter modelling scenarios for 2023/24. The Trust has not got a robust tool to undertake similar analysis (assessing actual outputs to those forecasted and modelled) to identify good practice and determine whether any enhancements are necessary for future modelling and forecasting.</li> </ul> <p><b>Theme:</b> Information, Data Quality &amp; Data Accuracy</p> <p><b>Risk &amp; Impact:</b> Winter resilience forecasting and modelling is ineffective with a failure to mitigate demand and capacity changes potentially impacting patient safety and staff wellbeing.</p>	4	<p><b>Agreed Actions:</b></p> <ol style="list-style-type: none"> <li>1) As part of the Forecasting &amp; Modelling SOP, confirm the template(s) to be used for in-house reports.</li> <li>2) Build WG winter modelling scenario work into the SOP.</li> </ol> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- Forecasting &amp; Modelling SOP approved in SP&amp;P BLT meeting.</li> <li>- Forecasting and modelling reports incorporating WG analysis and data assumptions</li> </ul>	Nov-25	Not Yet Due				Open
091-24/25	2024/25	FPC	Forecasting & Modelling	Reasonable	Rachel Marsh & Hugh Bennett	Rachel Marsh	Medium	5	<p><b>Forecasting and Modelling Group Meeting Administration</b></p> <p>The existence of a multi-disciplinary Forecasting and Modelling Group is a positive step in collaborative working, but it was difficult to evidence the level of discussion and scrutiny of modelling and forecasting activity as key decisions are not recorded, e.g. within a decision log.</p> <p>Predominantly, verbal updates were provided due to staff pressures. We were advised that written reports are provided where there is a particular forecasting or modelling output to be discussed, e.g. Omda report, but that some of the written reports may have gone to the informal weekly meetings rather than the monthly meetings that have a structured agenda.</p> <p>Similarly, while the Group's terms of reference detail the quorum arrangements, e.g. Chair or Vice Chair to be present along with a JCC representative, nothing is recorded to confirm the meeting attendance (also refer to Key Finding 3).</p> <p>A workplan and project tracker has been recently implemented however, its effectiveness is currently limited by staffing constraints, noting a lack of dedicated administrative support within the team. The workplan has nine actions recorded, but four do not record a timescale. Similarly, the project tracker has 16 actions, but timescales were unclear for seven actions and nine actions were overdue.</p> <p><b>Theme:</b> Governance</p> <p><b>Risk &amp; Impact:</b> Meetings may not be effective if they are not planned appropriately, and there may be a lack of accountability of issues escalated.</p>	5	<p><b>Agreed Actions:</b></p> <ol style="list-style-type: none"> <li>1) Introduce a AAA report for the Forecasting &amp; Modelling Group and confirm governance route.</li> <li>2) Continue to strengthen focus on work plan through the F&amp;M Group, as it was only recently introduced before the audit.</li> </ol> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- AAA reports (taken to SP&amp;P BLT meeting).</li> <li>- Use an up to date work plan, articulated through the AAA.</li> </ul>	Nov-25	Not Yet Due				Open
092-24/25	2024/25	FPC	Forecasting & Modelling	Reasonable	Hugh Bennett	Rachel Marsh	Medium	6	<p><b>Oversight of Forecasting and Modelling Activity</b></p> <p>The Forecasting and Modelling Group's (FMG) terms of reference note that the "Group will report to the Executive Director of Strategy, Planning &amp; Performance who will determine the subsequent flow of information into the relevant setting." While verbal updates are provided to the Executive Director, who serves as the Executive Sponsor for the Group, there is a lack of clear onward reporting from the Group and the extent of oversight within the broader Trust governance framework could not be easily demonstrated.</p> <p>There was evidence of recent engagement that incorporates reporting of forecasting and modelling activity. For example, reporting to the Operations Directorate's weekly performance review meeting and Senior Leadership Team (SLT) meetings.</p> <p>However, wider reporting to Trust Board and its committees has been restricted to a closed session of Finance and Performance Committee (FPC) (16 July 2024) on the outcomes of the Emergency Medical Services (EMS) Demand and Capacity Review; and to both the FPC (17 September 2024) and the Trust Board (26 September 2024) concerning the closure of the EMS Operational Transformation Programme Board.</p> <p>As highlighted in objective 2, there was no reporting to the Trust Board or its committees on the recent winter planning exercise.</p> <p><b>Theme:</b> Governance</p> <p><b>Risk &amp; Impact:</b> Ineffective reporting could result in poor decision making and a lack of accountability and oversight.</p>	6	<p><b>Agreed Actions:</b></p> <ol style="list-style-type: none"> <li>1) Introduce AAA reports at FMG and SP&amp;P BLT.</li> <li>2) Winter modelling to be reported formally into Operations SLT.</li> </ol> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- AAA reports (FMG and SP&amp;P BLT), and</li> <li>- Operations SLT AAA report into ELT to show evidence of the winter modelling discussion.</li> </ul>	Oct-25	Not Yet Due				Open

093-24/25	2024/25	FPC	Forecasting & Modelling	Reasonable	Hugh Bennett	Rachel Marsh	Medium	7	<p><b>Organisational Learning</b></p> <p>There is no formal mechanism in place to capture good practice and lessons learnt arising from modelling and forecasting activity. As noted in objective 2, there have been no reflections from the 2024/25 winter planning exercise, but wider consideration is required to prompt if elements of the forecasting and modelling process needs to be corrected for future planning.</p> <p>We noted evidence of continuous improvement within Trust Board reporting (March 2025 - Actions to mitigate avoidable patient harm in the context of extreme and sustained pressure across urgent and emergency care); operational performance meetings in relation to the 111 Christmas forecasting (as noted in objective 2); and the EMS Operational Transformation Board Closure Report incorporated some lessons learnt in relation to the forecasting and modelling for the roster review.</p> <p>However, there is no structured process to prompt for these to be shared and to ensure that delivery of any actions arising from lessons learnt are effectively monitored.</p> <p><b>Theme:</b> Lessons Learnt</p> <p><b>Risk &amp; Impact:</b> Ineffective organisational learning could lead to missed opportunities for improvements and poor decision making.</p>	7	<p><b>Agreed Action:</b></p> <p>The Forecasting &amp; Modelling Report Tracker will record lessons learnt.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Forecasting &amp; Modelling Report tracker; and identified as part of the AAA reporting up to SP&amp;P BLT.</p>	Nov-25	Not Yet Due				Open	
101-24/25	2024/25	QuEST	Start of Shift Procedure	Limited	Sonia Thompson	Lee Brooks	Medium	1	<p><b>Awareness of SOP</b></p> <p>In February 2025, as part of the Quality &amp; Support days, Ambulance Care focused on enhancing the operational efficiency and safety of ambulance services, particularly through the lens of Shift Start and Vehicle Security during shifts.</p> <p>Weaknesses were noted in relation to awareness of the SOP, as well as completion of expected forms (see Key Finding 3) and the time taken to be taken to complete the checks.</p> <p>As has been reported within the Operations Quarterly Sub-Report (Q4) such has highlighted a training need. Whilst it is appreciated these results are specific to Ambulance Care, consideration should also be given to understanding the current practices applied within EMS to confirm awareness of the SOP.</p>	1	<p>Communications will be circulated to reinforce the SOP and its contents. The timing of this will coincide with the release of an updated SOP (as reflected in Key Finding 2).</p> <p><b>Expected Evidence of Implementation:</b> Copy of the communications.</p>	Oct-25	Not Yet Due				Open	<p><a href="#">25/26 Q2 Update:</a></p> <p>120925 (TMM) - Necessary changes will be made to the SOP following workshops on overruns and ongoing work with VDI checking. Following this, the SOP will be circulated.</p>
102-24/25	2024/25	QuEST	Start of Shift Procedure	Limited	Ben Collins	Lee Brooks	Medium	2	<p><b>Update to SOP to reflect current practices</b></p> <p>As detailed within the SOP for Start of Shift arrangements, staff must complete their legal VDI checks (Appendix 1) to comply with the Road Traffic Act, prior to mobilising any call.</p> <p>As reported from a recent Quality &amp; Support day, only 50% of those in Ambulance Care are completing the forms alongside the acknowledgments included in the MDVS, with the rest only using the MDVS. However, there is no reference to MDVS within the SOP which could raise confusion as to whether such is a supplement to, or replacement for, the VDI checks.</p> <p>Further, whilst the headings as per the MDVS correlate with the primary checks as included in the VDI form, the latter provides more detail/guidance for the driver completing.</p> <p>It is also noted that, as a result of the recent Quality &amp; Support Day, (see objective 5) there is a need to update the SOP to align with the needs of the NEPTS/Ambulance Care teams to 'ensure that all staff regardless of their specific roles are on the same page regarding shift commencement procedures.'</p>	2	<p>The Vehicle Accident Management Task &amp; Finish Group are currently reviewing VDI processes within the Trust in line with the Vehicle Accident Management Internal Audit actions. Given the correlation with this audit, the scope of this group will be expanded to include Start of Shift SOP arrangements. On agreement of the new process from the Task &amp; Finish Group, the SOP will be updated to reflect current practice. Senior Operations Team (SOT) will maintain oversight and responsibility of this audit action.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- AAA reports from the Task &amp; Finish Group to confirm agreed process;</li> <li>- copy of updated SOP to reflect practice, and</li> <li>- copy of AAA to approve amended SOP.</li> </ul>	Oct-25	Not Yet Due				Open	<p><a href="#">25/26 Q2 Update:</a></p> <p>240925 (TMM) The process of VDI is still being discussed in the T&amp;F Group, an options appraisal has been developed in draft however further discussions may confirm that an appraisal is not needed for VDI process. Further information being sought.</p>
103-24/25	2024/25	QuEST	Start of Shift Procedure	Limited	Ben Collins	Lee Brooks	High	3	<p><b>Lack of evidence to demonstrate compliance of checks</b></p> <p>As has been identified through the recent Ambulance Care Quality &amp; Support day, 50% of the staff involved (circa 162) completed the paper-based forms as per the SOP. It is not clear as to the completion rate for EMS as such was not the focus for their Quality &amp; Support day; however, the site visits undertaken during the course of audit fieldwork noted that no forms were completed and retained post completion of the checks.</p> <p>Recognising the legal requirement for the completion of these checks, and wider compliance with the SOP, consideration should be given to the development of an electronic version of the VDI form, to be made available via the iPads. The receipt into a central mailbox / repository would allow for a date/time stamp to be actioned therefore providing an opportunity to understand the timeframe for completion amongst crews – the output of which can be reported and escalated as appropriate.</p> <p>Consideration could also be given to the inclusion of sign off for clinical and equipment checks noting there is no specified requirement, as per the SOP, for such to be documented (see objective 5).</p>	3	<p>The Vehicle Accident Management T&amp;F Group are currently reviewing VDI processes within the Trust in line with the Vehicle Accident Management Internal Audit actions, this includes the process to demonstrate compliance and reporting of checks. Given the correlation with this audit, the scope of this group will be expanded to include Start of Shift SOP arrangements. SOT will maintain oversight and responsibility of this audit action.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- AAA reports from the Task &amp; Finish Group to confirm discussions on the VDI process and reporting mechanisms, and</li> <li>- an updated version of the SOP</li> </ul>	Oct-25	Not Yet Due				Open	<p><a href="#">25/26 Q2 Update:</a></p> <p>240925 (TMM) The process of VDI is still being discussed in the T&amp;F Group, an options appraisal has been developed in draft however further discussions may confirm that an appraisal is not needed for VDI process. Further information being sought.</p>

104-24/25	2024/25	QuEST	Start of Shift Procedure	Limited	Sonia Thompson & Mark Harris	Lee Brooks	Medium	4	<p><b>Review of Consumables</b></p> <p>There is a minimum list of expected consumables and equipment to be retained on EMS and Ambulance Care vehicles. Noting the lesser amount on the latter it is easier to maintain a regular stock check of the items.</p> <p>However, with EMS, there is the risk that crew members will pick up what they think is needed within the time period available to complete the check rather than there being a routine stock count completed, which will also pick up expiry dates for items.</p> <p>We appreciate that consumables review will be undertaken on behalf of the paramedics at MRDs; however consideration should be given to a regular scheduled review of consumables at the stations or through the MRD as part of the wider cleaning schedule to rationalise the consumables held and prevent wastage / excessive ordering.</p>	4	<p>The Trust accepts this finding and recognises that whilst there is a list of minimal consumables in MRD this currently is not applied at ambulance stations. The Operations Directorate will share comms to staff on the minimal list of consumables required for vehicles to reinforce the amount that needs to be held. The list will also be placed on all relevant vehicles. Consideration will also be given to incorporate a regular scheduled review of consumables.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- A copy of list of consumables that will be added to vehicles,</li> <li>- a copy of the comms to reinforce the consumable amounts</li> <li>- AAA report from EMG (EMS Management Group)</li> <li>- AAA report from Ambulance Care Service Management Meeting to confirm discussions on scheduled review consideration.</li> </ul>	Oct-25	Not Yet Due			Open	<p><a href="#">25/26 O2 Update:</a> 150925 (TWM) The list of consumables along with a bulletin will be circulated the same time as the amended SOP. (ref action 101-24/25)</p>
105-24/25	2024/25	QuEST	Start of Shift Procedure	Limited	Ben Collins	Lee Brooks	High	5	<p><b>Reporting</b></p> <p>There is no evidence of routine reporting being undertaken to measure compliance with the SOP, timeliness and accuracy of completion to permit escalation of concerns, should they be identified.</p> <p>Whilst the output of the Quality &amp; Support day has been reported at Committee level, this related to an exercise completed in quarter 4 and was only in relation to Ambulance Care.</p> <p>The use of a central repository for completed forms (see Key Finding 3) would help facilitate reporting.</p>	5	<p>EMG (EMS Management Group) will review the main key points of the SOP and potential compliance measurements and will complete a dip sample exercise based on the key components to review compliance and discuss next steps to include regular routine reporting. SOT will maintain oversight and responsibility of this audit action.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- AAA reports from EMG (EMS Management Group) into SOT (Senior Operations Team) to determine discussions on the SOP, and</li> <li>- the results of the dip sample / next steps discussions.</li> </ul>	Dec-25	Not Yet Due			Open	<p><a href="#">25/26 O2 Update:</a> 150925 (TWM) Following the workshops on Overruns, Departmental Actions Cards are being created which will allow departments to measure outcomes of the SOP requirements.</p>
106-24/25	2024/25	FPC	Capital Systems	Reasonable	Head of Capital Development	Chris Turley	Medium	1	<p><b>Capital Procedures</b></p> <p>Whilst there are a number of processes in place at the Trust to support the progression of a capital project from inception to closure, they are not formally documented. It is acknowledged that the principles of Prince 2 methodology are applied, and guidance has been provided in relation to the core tasks applicable within each of the RIBA stages.</p> <p>We have evidenced at other NHS organisations the application of a project checklist for completion as each stage of the project progresses; and such could be extended to include expectations for receipt of key documentation such as:</p> <ul style="list-style-type: none"> <li>- declarations of interest, collusion certificates (see objective 2),</li> <li>- confirmation of parent company guarantees (if applicable)</li> <li>- insurance documentation and the minimum coverage amounts based on project size and risk,</li> <li>- confirmation that the successful / unsuccessful award notifications have been issued to the contractors.</li> </ul>	1	<p>Develop project checklist for adoption by all schemes (and tailored accordingly to each as required).</p> <p><b>Expected Evidence of Implementation:</b> Project checklist issued to Project Managers for adoption within project documentation.</p>	Sep-25	Met			Closed in Quarter	<p><a href="#">25/26 O2 Update:</a> 220925 (JW) Project checklist has been drafted and first draft shared with Project Managers. To note that this document will continue to be refined, and will need to be adapted for each individual project given that schemes vary in type, scale and the actions required to deliver them. Propose to close this action as the document is in development and will be adopted by projects. Evidence supplied to support closure of action.</p>
107-24/25	2024/25	FPC	Capital Systems	Reasonable	Head of Capital Development & Deputy Head of Procurement	Chris Turley	High	2	<p><b>Declarations of Interest / Non-Collusion</b></p> <p>There was no evidence to confirm independence from the contractors submitting tenders by the NWSSP Procurement officers involved in the procurement exercises. Further, there was no evidence of a non-collusion form having been completed by the contractor upon return of their tender documentation.</p> <p>Management advised that the commercial, technical and financial information received from contractors will not be released unless affirmations of independence have been received (the same being applicable in respect of non-collusion). However, in the instances of the four signed contracts reviewed, NWSSP Procurement confirmed the officers were not asked, therefore lessening this 'control'.</p>	2	<p>Project Managers to hold a copy of completed DOIs returned to NWSSP before tender submissions are released for scoring. This will be recorded on the project checklist.</p> <p>Provide a copy of the Internal Audit report to request NWSSP Procurement confirm in writing that they will fulfil their requirements in respect of ensuring due independence / governance in all future procurement. Further to include in the Procurement Outcome Report (POR); previously the CABR, the necessary confirmation of independence by all NWSSP officers involved in the process and receipt of non-collusion forms. Expected</p> <p><b>Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- Project checklist updated by Project Managers to reflect retention of Trust DOI forms.</li> <li>- Email to provide Internal Audit report to NWSSP Procurement with a request that they update the POR as per the findings of the audit report and provide written confirmation of independence and confirmation of non-collusion forms.</li> </ul>	Nov-25	Not Yet Due			Open	
108-24/25	2024/25	FPC	Capital Systems	Reasonable	Capital Programme Manager	Chris Turley	Medium	3	<p><b>Completion of contract documentation</b></p> <p>The finalised contract for the EV Charging Infrastructure was not available for review at the date of audit fieldwork. From review of the EV Project Board minutes, that at the date of fieldwork completion, two of the three charging stations had been installed. At the date of this report, we note that all work has been completed.</p> <p>We understand that the signed documentation is currently being chased by both the Trust and NWSSP Procurement Services for finalisation, but such should be in place prior to actioning the purchase order on Oracle (which we noted had been done), including evidence of parent company guarantee (see Key Finding 1).</p> <p>The appointment was made following a mini competition from the ESPO Vehicle Charging Infrastructure (VCI) Framework – financial risk reduced with the purchase order placed on Oracle, but from a service delivery perspective, should issues be encountered post completion, there is no contractual documentation to support responsibility.</p>	3	<p>Continue to chase the signed Framework Agreement for the EV Charging Infrastructure work.</p> <p><b>Expected Evidence of Implementation:</b> Evidence of chasing and/or signed Framework Agreement.</p>	Sep-25	Met			Closed in Quarter	<p><a href="#">25/26 O2 Update:</a> 220925 (JW) This was progressed in June 2025 and we were informed that BP would not be able to provide a signed copy and challenged that further with no further response. To-date, a signed agreement has not been provided by the company. Evidence supplied to support closure of action.</p>
109-24/25	2024/25	FPC	Capital Systems	Reasonable	Executive Director of FinCOR and Board Secretary	Chris Turley	Medium	4	<p><b>Annotation of contracts</b></p> <p>All of the four contracts reviewed are standard JCT contracts. Amendment to the standard form i.e. inclusion of values, dates, delay damages etc should be annotated (page by page) so as to demonstrate acceptance by both parties; in addition to the expected formal signing of the contract. However, this was only evidenced for one contract noting this had been applied due to an error in the contractual value that had been recorded.</p>	4	<p>Cost Advisor to highlight specific detail included in the standard JCT contract. Changes to be annotated a point of signature.</p> <p><b>Expected Evidence of Implementation:</b> Example of a signed JCT contract with changes annotated</p>	Apr-26	Not Yet Due			Open	

110-24/25	2024/25	FPC	Capital Systems	Reasonable	Head of Capital Development	Chris Turley	Medium	5	<b>Contract Retention Period</b> The four contracts that were available at this review were executed as a deed, which conveys longer liability periods of 12 years or the useful life of the associated building/s (or their disposal). Accordingly, the proposed retention period of six years is insufficient.	5	All contract documentation stored in the Operating & Maintenance (O&M) manual structure and noted on the project checklist.  Internal Audit report to be provided to Records Management Team with request that the next update to the Trust's Record Management Policy recognises compliance with the NHS Code of Practice but provides additional confirmation of the process to be applied for contracts executed as deed.  <b>Expected Evidence of Implementation:</b> - Screenshot of JCT contract held in O&M folder for scheme completed (2024/25 schemes for purpose of evidence). - Evidence of Internal Audit report provided to Records Services and Archives Manager.	Jul-25	Met			Closed in Quarter	<a href="#">25/26 O2 Update:</a> 220925 (JW) - Contract copies stored in O&M manual as schemes complete. Project Checklist starting to be used for 25/26 schemes - no contracts through yet but this will be BAU going forward. <b>Propose to close.</b> Evidence supplied to support proposed closure.
111-24/25	2024/25	FPC	111 Wales Website	Limited	Product Manager: Data & Applications	Jonny Sammut	High	1	<b>Security</b> The website was developed using .NET Framework 4.5, which has been unsupported since April 2022 and is vulnerable to significant security risks.  In addition the SSL/TLS configuration received only a 'B' rating, we also note that although strong passwords are required MFA is not currently implemented.  Our review of the group membership for updating content identified a 12 members who retain access despite no longer being responsible for content, including at least one individual who has left the Trust.	1.1	An improvement plan will be developed to upgrade from .NET 4.5 to .NET 4.7 or above. This will offer an estimate of the time and effort required to do this in isolation. However, there is also an existing plan to update the Content Management System (CMS) of the site (subject to funding), which enables us to mandate in the requirements specification that .NET version 4.7 or above is used when migrating the site to the new CMS.  <b>Expected Evidence of Implementation:</b> Upgrade decision (i.e. either a standalone upgrade with existing arrangements, or upgrade during migration to new hosting arrangements) to be approved by Digital Front End project group (seen by agenda and minutes / decision log).	Sep-25	Met		Closed in Quarter	<a href="#">25/26 O2 Update:</a> 240925 (LS) The work involved in upgrading to .NET4.7 has been scoped with an outline plan developed. Recommendation is to plan the upgrade immediately following a CMS upgrade. Digital Front End (DfE) workstream group will monitor progress of both these activities in coming months. <b>Proposed for Closure</b> with the improvement plan supplied as evidence.	
112-24/25	2024/25	FPC	111 Wales Website	Limited	Product Manager: Data & Applications	Jonny Sammut	High	1	<b>Security</b> The website was developed using .NET Framework 4.5, which has been unsupported since April 2022 and is vulnerable to significant security risks.  In addition the SSL/TLS configuration received only a 'B' rating, we also note that although strong passwords are required MFA is not currently implemented.  Our review of the group membership for updating content identified a 12 members who retain access despite no longer being responsible for content, including at least one individual who has left the Trust.	1.2	The supplier, Rackspace, controls the security to the platform, we will engage with them to ascertain whether MFA can be implemented. It should be noted we are also looking to review hosting arrangements in the near future.  <b>Expected Evidence of Implementation:</b> Clarification by supplier whether MFA is possible (evidenced via email trail or written response) and if so, an agreed timeline for implementation (dependent on funding).	Sep-25	Met		Closed in Quarter	<a href="#">25/26 O2 Update:</a> 240925 (LS) Following conversations with the supplier, it has been confirmed that access to the supplier servers is via remote desktop and secure VPN (common practice), as such MFA is not a suitable or necessary mechanism. Further detail and assurance has been provided by the supplier on their security mechanism and protocols. <b>Propose closure</b> of the action as the recommendation of implementing MFA is not deemed suitable for this particular platform.	
113-24/25	2024/25	FPC	111 Wales Website	Limited	Product Manager: Data & Applications	Jonny Sammut	High	1	<b>Security</b> The website was developed using .NET Framework 4.5, which has been unsupported since April 2022 and is vulnerable to significant security risks.  In addition the SSL/TLS configuration received only a 'B' rating, we also note that although strong passwords are required MFA is not currently implemented.  Our review of the group membership for updating content identified a 12 members who retain access despite no longer being responsible for content, including at least one individual who has left the Trust.	1.3	Access permissions to the CMS system will be reviewed and updated accordingly.  <b>Expected Evidence of Implementation:</b> Revision of access to the CMS system (evidenced with written confirmation to the Digital Front End project group of who retains access).	Oct-25	Not Yet Due		Open	-	
114-24/25	2024/25	FPC	111 Wales Website	Limited	Product Manager: Data & Applications	Jonny Sammut	Medium	2	<b>DR Plan</b> The disaster recovery plan remains informal, lacking a documented standard operating procedure (SOP) which clearly sets out how to restore services, where key files are and details of alternate logins.	2	The team will take the informal SOP for the recovery of services which was last tested in 2024 and create a formal SOP with the appropriate level of signoff.  <b>Expected Evidence of Implementation:</b> Formal SOP will be available for verification	Nov-25	Not Yet Due		Open	-	
115-24/25	2024/25	FPC	111 Wales Website	Limited	Director of Digital	Jonny Sammut	Medium	3	<b>Resource and Improvement</b> The resource available for the technical management of the website is low, with only two members of staff having access. This results in a risk of loss of access and the inability to improve the site beyond ensuring it operates and rectifying critical weaknesses. We note that a 3 to 5 year development plan has been proposed by the Digital Front End Project team to Welsh Government and the outcome for funding is yet to be determined.	3	A business case has been drafted to improve the 111 Wales Website, and put in place a team which can manage and maintain it long term.  Discussions with Welsh Government are ongoing regarding funding for this case, and ensuring it meets commissioner expectations.  The outcome of this is a pre-requisite for any long-term resource and improvement action that can be taken.  However, in the meantime, the two technical experts, will continue to manage urgent improvements to the website as required and progress the high priority actions identified under the Security section above.  <b>Expected Evidence of Implementation:</b> Submission of business case and review of feedback from WG.	Jan-26	Not Yet Due		Open	-	

116-24/25	2024/25	FPC	111 Wales Website	Limited	Director of Digital	Jonny Sammut	High	4	<b>Feedback and improvement</b> Patient feedback showed that 33% of respondents rated their overall experience as poor or very poor. However, there is no formal design framework or roadmap for designing and creating website content. The website's design is informally coordinated by the Quality and Patient Experience teams and we note that the governance structure has weakened following the disbandment of the former web and editorial boards. Updates are managed by a small team with limited capacity who primarily replicate content from the NHS 111 England website and content writing is minimal. Updates are performed on an ad hoc basis, and the team lacks the capacity to regularly review or optimise content.	4	A business case has been drafted for Welsh Government to fund a full 111 Wales Website team to manage and maintain it long term which would include patient experience and communications expertise.  The outcome of this business case is a pre-requisite for any long term resource and improvement action that can be taken.  However, in 2023, showing WAST's commitment to patient experience despite a lack of permanently funded resource in this service area, a user research project was commissioned, investigating the views and needs of the 111 web users. The findings of which have informed the business case, and will inform a roadmap related to design frameworks and user experience for a future team.  In the meantime, in collaboration between members of the Quality, Comms and Digital Directorates, urgent content updates will continue to be maintained, and headline messages to the public kept up to date.  <b>Expected Evidence of Implementation:</b> Submission of business case and review of feedback from WG	Jan-26	Not Yet Due				Open
117-24/25	2024/25	FPC	111 Wales Website	Limited	Product Manager: Data & Applications	Jonny Sammut	Medium	5	<b>Accessibility</b> The 111 website is expected to comply with WCAG standards for accessibility, such as screen reader compatibility and keyboard navigation and aims to achieve WCAG 2.1 Level AA. We note that work has been undertaken to improve accessibility, however there were unresolved issues, including with heading structure and unlabelled elements.	5	The team have previously engaged with Accessibility experts within the Government Digital Services and the 111 Wales website was last audited in 2023 and found to be compliant.  To ensure the website remains compliant following recent improvements, we will perform a gap analysis against the latest WCAG standards. If there are any discrepancies, we will develop an improvement plan in conjunction with them.  However, it should be noted, capacity to implement any significant accessibility requirements will be dependent on the outcome of the business case and funding decisions currently with Welsh Government.  <b>Expected Evidence of Implementation:</b> Improvement plan to meet WCAG standards developed and agreed by Digital Front End Project Group (evidenced through agenda and AAA / minutes)	Oct-25	Not Yet Due				Open
118-24/25	2024/25	FPC	111 Wales Website	Limited	Product Manager: Data & Applications	Jonny Sammut	Medium	6	<b>Search Engine Optimisation strategy</b> There is no formal SEO activity and our testing of search engine optimisation noted a score of 48 out of 100 when broader search engine optimisation criteria were assessed. These included mobile usability, metadata presence, keyword optimisation, backlink strategy, analytics use, and structured SEO planning. Issues include slow mobile load times, missing alt text, inconsistent use of meta tags, and no backlink-building efforts. It should be noted however that testing of SEO can vary and is very much at that point in time.	6	The team will undertake a review and selection of an SEO tool and will create an improvement plan subject to funding and resource availability to ensure that site SEO is maximised.  <b>Expected Evidence of Implementation:</b> SEO Tool in use by the Data Applications (dev) Team (evidenced by an updated SEO assessment within 6 months – no guarantee of a change in score noting the dependency on funding to enable any meaningful improvements to be made to the website.)	Dec-25	Not Yet Due				Open
119-24/25	2024/25	FPC	111 Wales Website	Limited	Assistant Director of Digital Services: Data & Analytics	Jonny Sammut	Medium	7	<b>Tracking of Site Use</b> Although Google Analytics is installed and available which would enable the Trust to track site use and performance and enable improvements this is not fully used and there is no active tracking of site metrics.	7	There are KPI (Key performance Indicators) for the 111 Wales website that are tracked and reported to both internally (to Digital Leadership Group and Finance & Performance Committee) and externally (via the Ambulance Service Indicators). The team will review those KPIs with the Business to understand the reporting requirements for future and create a delivery plan for any new KPI's that are potentially required.  <b>Expected Evidence of Implementation:</b> Delivery plan of any potential or future KPI's to be reported to Digital Leadership Group (evidenced by a written document proposing the plan).	Jan-26	Not Yet Due				Open

**Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With an Orange Header**  
**When reporting a recommendation as closed, please detail and supply email evidence to support this, clearly stating the recommendation in the email.**  
**When proposing a revised date, please include the rationale for the movement and any progress on the action to date**  
**ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND ON THE CORPORATE GOVERNANCE SIREN PAGE**

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Action No. in Mngt Response	Recommendation	Response No. in Audit	Management Response	Agreed Deadline in Report	Status: met or not met agreed deadline in report	1st revised date	2nd revised date	Closure Status	DIRECTORATE UPDATES Where a management action has not met the agreed or revised date, Director must include here: 1. Date of your update 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first
IA/2526-001	2025/26	PCC	Organisational Change	Reasonable	Karen Jones (Deputy Head of People Services)	Carl Kneeshaw	Medium	1	<p><b>Documented Procedures</b></p> <p>Several templates have been developed to support the OCP process, covering areas such as the rationale for change, consultation, and feedback. However, these templates are not currently available on the Trust's SharePoint site, leading to inconsistent use and the circulation of outdated versions. Additionally, the templates could be improved to prompt for key elements such as cost implications, resource capacity, and the approval process.</p> <p>There are currently no formal, documented procedures available to guide managers through the OCP process. Although People Services provide support during OCP delivery, the absence of clear guidance has contributed to uncertainty among staff. Feedback from staff involved in sample testing (see <b>Objective 2</b>) indicated that some had no prior experience with OCPs, resulting in a lack of clarity around roles and responsibilities, particularly regarding the timing of job description reviews and the completion of Equality and Quality Impact Assessments (EQIA and QJA).</p>	1.1	<p><b>Agreed Action:</b> There is an OCP toolkit for Managers, including template letters and standardised templates. However, these aren't stored on SIREN. The People Business Leader would share with the appropriate Manager, to ensure that letters that may change T3 &amp; C3 are not easily accessible without People Services advice. Following feedback from this audit and to raise line manager awareness of the OCP process we will include a Manager's Easy Read Guidance document, and a Manager's checklist, added to SIREN under People Services Toolkits.</p> <p><b>Expected Evidence of Implementation:</b> Managers Easy Read Guidance Document and a Managers Checklist of OCP toolkit available on SIREN under People Services Toolkits.</p>	Dec-25			Open		
IA/2526-002	2025/26	PCC	Organisational Change	Reasonable	Bev Flood (Head of People Services)	Carl Kneeshaw	Medium	1	<p><b>Documented Procedures</b></p> <p>Several templates have been developed to support the OCP process, covering areas such as the rationale for change, consultation, and feedback. However, these templates are not currently available on the Trust's SharePoint site, leading to inconsistent use and the circulation of outdated versions. Additionally, the templates could be improved to prompt for key elements such as cost implications, resource capacity, and the approval process.</p> <p>There are currently no formal, documented procedures available to guide managers through the OCP process. Although People Services provide support during OCP delivery, the absence of clear guidance has contributed to uncertainty among staff. Feedback from staff involved in sample testing (see <b>Objective 2</b>) indicated that some had no prior experience with OCPs, resulting in a lack of clarity around roles and responsibilities, particularly regarding the timing of job description reviews and the completion of Equality and Quality Impact Assessments (EQIA and QJA).</p>	1.2	<p><b>Agreed Action:</b> The All-Wales OCP process is the guide which steps out each consideration, however we will develop a more simplified guide for Managers on the People impact elements to consider- in the form of a flowchart.</p> <p><b>Expected Evidence of Implementation:</b> Flow chart available on SIREN under People Services toolkits</p>	Feb-26			Open		
IA/2526-003	2025/26	PCC	Organisational Change	Reasonable	Karen Jones (Deputy Head of People Services) / Bev Flood (Head of People Services)	Carl Kneeshaw	High	2	<p><b>Organisational Change Planning and Coordination</b></p> <p>Historically, OCP-related activity has been treated as business-as-usual within the Trust. However, the growing volume of transformational change has exceeded existing capacity. At the time of audit, the People &amp; Culture Directorate was managing approximately 100 active cases, including nine OCPs within a single area. Limited visibility of upcoming service-led changes continues to hinder effective resource planning.</p> <p>The NHS Wales Organisational Change Policy defines change as having occurred when it is "likely to have a significant impact on the nature of the work performed or the arrangements or conditions under which the work is carried out." (p.7). Despite this, there is currently no mechanism in place to ensure that significant organisational change is consistently planned and co-ordinated across the Trust, particularly in relation to the alignment of change community and People &amp; Culture resources.</p> <p>The People and Culture Directorate Plan records some change management support for 2025/26 (e.g. Ambulance Care and APP), but no entries were available for 2024/25, limiting its use for OCP audit sampling.</p>	2.1	<p><b>Agreed Action:</b> Only large OCPs are recorded on the People and Culture Directorate Plan as OCPs are part of BAU for the directorate and cannot always be forecast or anticipated. The guidance for managers and leaders will include reference to early notification to the People Services Team so better planning and scheduling can be implemented to avoid resourcing issues wherever possible.</p> <p><b>Expected Evidence of Implementation:</b> Manager's Easy Read Guidance Document and a Manager's Checklist of OCP Toolkit</p>	Dec-25			Open		
IA/2526-004	2025/26	PCC	Organisational Change	Reasonable	Karen Jones (Deputy Head of People Services) / Bev Flood (Head of People Services)	Carl Kneeshaw	High	2	<p><b>Organisational Change Planning and Coordination</b></p> <p>Historically, OCP-related activity has been treated as business-as-usual within the Trust. However, the growing volume of transformational change has exceeded existing capacity. At the time of audit, the People &amp; Culture Directorate was managing approximately 100 active cases, including nine OCPs within a single area. Limited visibility of upcoming service-led changes continues to hinder effective resource planning.</p> <p>The NHS Wales Organisational Change Policy defines change as having occurred when it is "likely to have a significant impact on the nature of the work performed or the arrangements or conditions under which the work is carried out." (p.7). Despite this, there is currently no mechanism in place to ensure that significant organisational change is consistently planned and co-ordinated across the Trust, particularly in relation to the alignment of change community and People &amp; Culture resources.</p> <p>The People and Culture Directorate Plan records some change management support for 2025/26 (e.g. Ambulance Care and APP), but no entries were available for 2024/25, limiting its use for OCP audit sampling.</p>	2.2	<p><b>Agreed Action:</b> An OCP tracker will be established so multiple teams across People &amp; Culture can review, update and have better oversight of the OCPs in existence across the organisation. This will lead to better oversight.</p> <p><b>Expected Evidence of Implementation:</b> OCP Tracker in existence (exploration if this can be done using the same software review for case management)</p>	Jan-26			Open		

IA/2526-005	2025/26	PCC	Organisational Change	Reasonable	Karen Jones (Deputy Head of People Services) / Bev Flood (Head of People Services)	Carl Kneeshaw	High	2	<p><b>Organisational Change Planning and Coordination</b></p> <p>Historically, OCP-related activity has been treated as business-as-usual within the Trust. However, the growing volume of transformational change has exceeded existing capacity. At the time of audit, the People &amp; Culture Directorate was managing approximately 100 active cases, including nine OCPs within a single area. Limited visibility of upcoming service-led changes continues to hinder effective resource planning.</p> <p>The NHS Wales Organisational Change Policy defines change as having occurred when it is "likely to have a significant impact on the nature of the work performed or the arrangements or conditions under which the work is carried out" (p.7). Despite this, there is currently no mechanism in place to ensure that significant organisational change is consistently planned and co-ordinated across the Trust, particularly in relation to the alignment of change community and People &amp; Culture resources.</p> <p>The People and Culture Directorate Plan records some change management support for 2025/26 (e.g. Ambulance Care and APP), but no entries were available for 2024/25, limiting its use for OCP audit sampling.</p> <p>Audit testing highlighted the following key issues:</p>	2.3	<p><b>Agreed Action:</b> Project Classification: There are projects which will be led by Project Managers, Planning or SROs, that will have a people impact and some OCPs which only have a people element, e.g. restructures that People Services will support. Where OCPs are part of a project that has a dedicated project manager this is treated as a formal project. Both formal and informal OCPs will be captured on the OCP tracker.</p> <p><b>Expected Evidence of Implementation:</b> Review of OCP Tracker and People and Culture Directorate Plan. All projects captured on OCT Tracker.</p>	Jan-26								Open
IA/2526-006	2025/26	PCC	Organisational Change	Reasonable	Karen Jones (Deputy Head of People Services) / Bev Flood (Head of People Services)	Carl Kneeshaw	High	2	<p><b>Organisational Change Planning and Coordination</b></p> <p>Historically, OCP-related activity has been treated as business-as-usual within the Trust. However, the growing volume of transformational change has exceeded existing capacity. At the time of audit, the People &amp; Culture Directorate was managing approximately 100 active cases, including nine OCPs within a single area. Limited visibility of upcoming service-led changes continues to hinder effective resource planning.</p> <p>The NHS Wales Organisational Change Policy defines change as having occurred when it is "likely to have a significant impact on the nature of the work performed or the arrangements or conditions under which the work is carried out" (p.7). Despite this, there is currently no mechanism in place to ensure that significant organisational change is consistently planned and co-ordinated across the Trust, particularly in relation to the alignment of change community and People &amp; Culture resources.</p> <p>The People and Culture Directorate Plan records some change management support for 2025/26 (e.g. Ambulance Care and APP), but no entries were available for 2024/25, limiting its use for OCP audit sampling.</p> <p>Audit testing highlighted the following key issues:</p>	2.4	<p><b>Agreed Action:</b> Experience and Support: OCP toolkit will be made available on SIREN and People Services support is always available for OCP processes.</p> <p><b>Expected Evidence of Implementation:</b> PDF read only copies of OCP toolkit available on SIREN under People Services Toolkits.</p>	Dec-25								Open
IA/2526-007	2025/26	PCC	Organisational Change	Reasonable	Liz Rogers (Deputy Director of People Services) / Bev Flood (Head of People Services)	Carl Kneeshaw	Medium	3	<p><b>Monitoring and Reporting Organisational Change</b></p> <p>There is currently no robust mechanism in place to track OCPs across the Trust, nor are there independent checks to confirm effective application. This limits the ability to confirm whether change is being managed consistently, with appropriate oversight and opportunities for continuous improvement. While our testing of four OCPs found that trade union representatives were actively keeping their counterparts informed, there is opportunity to strengthen governance arrangements. In particular, more formalised reporting of organisational change at a trade union level would enhance transparency and support more consistent engagement.</p>	3.1	<p><b>Agreed Action:</b> An OCP tracker will be established so multiple teams across People &amp; Culture can review, update and have better oversight of the OCPs in existence across the organisation.</p> <p><b>Expected Evidence of Implementation:</b> OCP Tracker in existence</p>	Jan-26							Open	
IA/2526-008	2025/26	PCC	Organisational Change	Reasonable	Liz Rogers (Deputy Director of People Services) / Bev Flood (Head of People Services)	Carl Kneeshaw	Medium	3	<p><b>Monitoring and Reporting Organisational Change</b></p> <p>There is currently no robust mechanism in place to track OCPs across the Trust, nor are there independent checks to confirm effective application. This limits the ability to confirm whether change is being managed consistently, with appropriate oversight and opportunities for continuous improvement. While our testing of four OCPs found that trade union representatives were actively keeping their counterparts informed, there is opportunity to strengthen governance arrangements. In particular, more formalised reporting of organisational change at a trade union level would enhance transparency and support more consistent engagement.</p>	3.2	<p><b>Agreed Action:</b> A quarterly review of OCPs in progress and completed will be undertaken to include lessons learned and benefits realisation.</p> <p><b>Expected Evidence of Implementation:</b> Quarterly reviews completed</p>	Apr-26							Open	
IA/2526-009	2025/26	PCC	Organisational Change	Reasonable	Liz Rogers (Deputy Director of People Services) / Bev Flood (Head of People Services)	Carl Kneeshaw	Medium	3	<p><b>Monitoring and Reporting Organisational Change</b></p> <p>There is currently no robust mechanism in place to track OCPs across the Trust, nor are there independent checks to confirm effective application. This limits the ability to confirm whether change is being managed consistently, with appropriate oversight and opportunities for continuous improvement. While our testing of four OCPs found that trade union representatives were actively keeping their counterparts informed, there is opportunity to strengthen governance arrangements. In particular, more formalised reporting of organisational change at a trade union level would enhance transparency and support more consistent engagement.</p>	3.3	<p><b>Agreed Action:</b> A high level OCP update will be provided at Corporate Partnership Forum (CPF) for activity relating to that Directorate to ensure Trade Union awareness (OCP details will not be subject to discussion at the Local Partnership Form (LPF) meetings due to potential issues regarding confidentiality).</p> <p><b>Expected Evidence of Implementation:</b> Minutes of CPF Meeting</p>	Feb-26							Open	
IA/2526-010	2025/26	PCC	Organisational Change	Reasonable	Liz Rogers (Deputy Director of People Services)	Carl Kneeshaw	Medium	4	<p><b>Temporary Appointments</b></p> <p>The NHS Wales Organisational Change Policy (p.27) states that "Where an employee has been seconded or acted up in a post for a period of four continuous years or more, on the date on which they are displaced this will be considered to be their substantive post." However, there is no robust mechanism in place within the Trust to monitor the duration of temporary appointments. While it is expected that job role reviews during restructures will identify such cases, responsibility for monitoring rests with individual line managers.</p> <p>As part of our audit, we obtained a system-generated report from ESR; however, it did not clearly identify employees who had been in temporary posts for more than four years. We noted one case where an employee's temporary post began on 9 March 2020. We have since been advised that this individual was appointed on a permanent basis in December 2021, but the ESR system has not been updated to reflect this change.</p>	4.1	<p><b>Agreed Action:</b> Approval from Recruitment Control Panel (RCP) for temporary/FTC/secondment appointments will be dip sampled using TRAC and ESR to establish if change requests are being managed effectively.</p> <p><b>Expected Evidence of Implementation:</b> Dip sampling has taken place.</p>	Mar-26							Open	

IA/2526-011	2025/26	PCC	Organisational Change	Reasonable	Liz Rogers (Deputy Director of People Services)	Carl Kneeshaw	Medium	4	<p><b>Temporary Appointments</b></p> <p>The NHS Wales Organisational Change Policy (p.27) states that "Where an employee has been seconded or acted up in a post for a period of four continuous years or more, on the date on which they are displaced this will be considered to be their substantive post." However, there is no robust mechanism in place within the Trust to monitor the duration of temporary appointments. While it is expected that job role reviews during restructures will identify such cases, responsibility for monitoring rests with individual line managers.</p> <p>As part of our audit, we obtained a system-generated report from ESR; however, it did not clearly identify employees who had been in temporary posts for more than four years. We noted one case where an employee's temporary post began on 9 March 2020. We have since been advised that this individual was appointed on a permanent basis in December 2021, but the ESR system has not been updated to reflect this change.</p>	4.2	<p><b>Agreed Action:</b> Reminder to LMs/recruiting managers about the need to ensure that ESR holds the correct employment status of team members will be communicated via SIREN.</p> <p><b>Expected Evidence of Implementation:</b> Notice on SIREN</p>	Dec-25					Open
IA/2526-012	2025/26	PCC	Organisational Change	Reasonable	Liz Rogers (Deputy Director of People Services)	Carl Kneeshaw	Medium	4	<p><b>Temporary Appointments</b></p> <p>The NHS Wales Organisational Change Policy (p.27) states that "Where an employee has been seconded or acted up in a post for a period of four continuous years or more, on the date on which they are displaced this will be considered to be their substantive post." However, there is no robust mechanism in place within the Trust to monitor the duration of temporary appointments. While it is expected that job role reviews during restructures will identify such cases, responsibility for monitoring rests with individual line managers.</p> <p>As part of our audit, we obtained a system-generated report from ESR; however, it did not clearly identify employees who had been in temporary posts for more than four years. We noted one case where an employee's temporary post began on 9 March 2020. We have since been advised that this individual was appointed on a permanent basis in December 2021, but the ESR system has not been updated to reflect this change.</p>	4.3	<p><b>Agreed Action:</b> Quarterly reporting for temporary/FTC/secondment appointments and reviewed by People Service Team and Workforce Planning Team.</p> <p><b>Expected Evidence of Implementation:</b> Quarterly report.</p>	Apr-26					Open
IA/2526-013	2025/26	PCC	Organisational Change	Reasonable	Liz Rogers (Deputy Director of People Services)	Carl Kneeshaw	Medium	5	<p><b>Organisational Learning</b></p> <p>Our review of sampled OCPs identified varying approaches to capturing lessons learned and benefits realisation:</p> <ul style="list-style-type: none"> <li>- APP: As a formal project, APP maintained a lessons learned log; however, this has not been widely shared. A populated benefits register exists, though it was considered too early to record benefits realisation. Initial post-implementation feedback was gathered, with a further session planned for September 2025.</li> <li>- Volunteers Services: No lessons learned, or benefits realisation have been recorded to date. A six-monthly review of the reconfigured service is, however, planned.</li> <li>- Bryn Tirion Relocation: The Project Initiation Document references post-project evaluation and lessons learned. While lessons were discussed at the May 2025 Project Board, they have not been formally documented. Similarly, no benefits realisation has been undertaken.</li> <li>- PTR: No formal documentation of lessons learned, or benefits realisation was identified. While consultation outcomes indicate that reviews of the operating model are planned at six- and twelve-months post implementation, we were advised that these discussions have occurred informally at team meetings and have not been formally recorded.</li> </ul> <p>Currently, there is no structured process in place to prompt or support the consistent recording and sharing of lessons learned of benefits realisation across OCPs.</p>	5.1	<p><b>Agreed Action:</b> Formal projects will continue to review lessons learnt and benefits realisation as part of the formal project management process. Those involved (People &amp; Culture/Business areas/TUPs) in an OCP process will undertake reviews on a quarterly basis to review the effectiveness of the OCP processes in train and completed; and consider opportunities for continuous improvement as well as the realisation of benefits. This will be supported by a checklist.</p> <p><b>Expected Evidence of Implementation:</b> Checklist completed 3 months post OCP</p>	Apr-26					Open

IA/2526-014	2025/26	PCC	Organisational Change	Reasonable	Sarah Davies (Head of Change & People Insights)	Carl Kneeshaw	Medium	5	<p><b>Organisational Learning</b></p> <p>Our review of sampled OCPs identified varying approaches to capturing lessons learned and benefits realisation:</p> <p>- APP: As a formal project, APP maintained a lessons learned log; however, this has not been widely shared. A populated benefits register exists, though it was considered too early to record benefits realisation. Initial post-implementation feedback was gathered, with a further session planned for September 2025.</p> <p>- Volunteers Services: No lessons learned, or benefits realisation have been recorded to date. A six-monthly review of the reconfigured service is, however, planned.</p> <p>- Bryn Tirlon Relocation: The Project Initiation Document references post-project evaluation and lessons learned. While lessons were discussed at the May 2025 Project Board, they have not been formally documented. Similarly, no benefits realisation has been undertaken.</p> <p>- PTR: No formal documentation of lessons learned, or benefits realisation was identified. While consultation outcomes indicate that reviews of the operating model are planned at six- and twelve-months post implementation, we were advised that these discussions have occurred informally at team meetings and have not been formally recorded.</p> <p>Currently, there is no structured process in place to prompt or support the consistent recording and sharing of lessons learned of benefits realisation across OCPs.</p>	5.2	<p><b>Agreed Action:</b> Whilst our approach is primarily culture and capability focussed, rather than process driven, we recognise the importance of being able to evidence benefits and lessons learned. We will be documenting lessons learned through change initiatives and sharing these widely through a case study approach, highlighting practical examples of people focused change and the impact on individuals, teams and outcomes. These case studies will be made available through our Change Community and other internal channels (including the CMT Change Management Workstream) helping to spread good practice, prompt reflection and inspire local adaptation. As a tangible measure of impact, we will also monitor relevant NHS Wales Staff Survey indicators to help track cultural shifts over time. This will be supplemented by qualitative feedback gathered through our engagement activities.</p> <p><b>Expected Evidence of Implementation:</b> Document lessons learned via case studies, share widely across the organisation and track impact through relevant staff survey indicators - 23d: I am involved in deciding on changes introduced that impact my work/area/tea/ department</p>	Mar-27						Open
IA/2526-015	2025/26	FPC	Manchester Arena Inquiry	Substantial	Judith Bryce (ADO - National Operations & Support)	Lee Brooks	Medium	1	<p><b>Impact of MIST Day Non-Attendance</b></p> <p>In relation to four recommendations from the MAI (including one not selected for sample testing), the Trust has developed and adopted specific measures to enhance its ability to respond effectively to a major incident. These measures were supported by face-to-face training sessions delivered through the Trust's MIST days. However, analysis of attendance data highlights potential gaps in training coverage:</p> <p>(i) <b>Ten Second Triage Tool (TST)/Major Incident Triage Tool (MITT)</b> – These tools represent improved triage arrangements adopted by multi-agency emergency services across Wales. Training was delivered via a 17-slide presentation during the 2023/24 MIST days. However, attendance records indicate that 194 Emergency Medical Services (EMS) staff and 112 Ambulance Care Services (ACS) staff did not attend (approximately 10% of the workforce). There is no evidence to confirm whether these staff received the training through alternative means.</p> <p>(ii) <b>Pax Carry Sheet</b> – This lightweight, high-quality, and versatile rescue aid was procured for every emergency vehicle across the Trust. Training was delivered via a single slide within the broader 'Safer Handling' session during the 2024/25 MIST days. Attendance data shows that 168 EMS staff and 65 ACS staff did not attend (approximately 11% of the workforce), and again, there is no evidence of alternative training provision for these staff.</p> <p>Whilst we acknowledge that an acceptable MIST compliance was deemed to have been reached, to facilitate 'go live' of the equipment from 1 April 2024 (81.45% as at 12 March 2024), review of the Trust's current training arrangements did not identify any plans to provide further coverage of these specific training needs.</p> <p>While the financial submission to the NHS Wales Joint Commissioning Committee (JCC) highlights training gaps, these relate specifically to additional training for major incident Commanders, rather than the frontline training requirements associated with the MAI report recommendations.</p>	1	<p><b>Agreed Action:</b> Following the feedback received, a multi-disciplinary team has identified solutions to address the issue. It was noted that the audit numbers (194 EMS and 112 ACAs) may have decreased as employees returned from absences like long-term illness or maternity leave. The ESR team is working to identify those who still need training. The Learning &amp; Development team will then engage with these individuals to ensure compliance with the new triage tools and PAX carry sheets.</p> <p>An eLearning package by L&amp;D has been recommended as the most efficient method for delivering remedial training. This package will be hosted on the Trust's LMS365 platform and made available to all staff, supporting ongoing CPD activities and new starters. We are consulting with neighbouring ambulance services for similar training materials to expedite this process. If unavailable, the Trust can develop its own materials using existing resources. Development of a new eLearning package may take until the end of Q3, but utilising existing packages could significantly reduce this timeline.</p> <p>The EMS Management Group (EMG) will monitor compliance and progress. Once available, the eLearning package will be a monthly agenda item for EMG to track progress and address any issues. Progress reports will be provided through standard assurance routes. We aim for completion by the end of the 2025/26 financial year, assuming all staff can undertake training. EMG will oversee this action until all necessary staff have completed the required training with approval for sign off to be sought from SOT.</p> <p><b>Expected Evidence of Implementation:</b> AAA reports from EMG into SOT on the monthly reporting of compliance.</p>	Feb-26						Open

**Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With an Orange Header**  
**When reporting a recommendation as closed, please detail and supply email evidence to support this, clearly stating the recommendation in the email.**  
**When proposing a revised date, please include the rationale for the movement and any progress on the action to date**  
**ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND ON THE CORPORATE GOVERNANCE SIREN PAGE**

Trust Ref No.	Audit Wales or HW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No. in Audit	Recommendation	Action No. in Mgt Response	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	(NB: Removed / No Longer Available from Apr25)	DIRECTORATE UPDATES Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first	Closure Status
155	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Kate Blackmore, Assistant Director of Quality Governance	Liam Williams		R2	<b>Quality Strategy Monitoring</b> There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports:  2.1 Provide timescales for the expected delivery of each action.  2.2 Differentiate between the progress of individual actions and strategic outputs, and  2.3 Ensure that progress reports are reported regularly and are included in the QuEST cycle of business.	R2	The approved Quality Plan will be supported by a robust implementation plan clearly articulating measurable actions and timescales for delivery against responsible and accountable owners.  Updates will be provided via the governance structures to ensure regular updates are provided to QuEST via the cycle of business.  The Assistant Director of Quality Governance will work with Corporate Governance leaders to ensure a clear cycle of updates and escalation is included within the implementation plan.  The review of minutes from QuEST Committee which includes these progress reports, through four cycles of business, will close this action.	Mar-26	Not Yet Due						Open
156	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Vince Bagloe, Head of Clinical Intelligence & Assurance	Liam Williams		R3	<b>Clinical Audit Plan</b> There are opportunities to further enhance reports on the Trust's Clinical Audit function, by:  3.1 More clearly highlighting any changes made to the approved Clinical Audit Plan; and  3.2 Capturing key findings, outcomes and learning from completed audits.	R3	We will review the communication lines between COGG, ELT and QuEST to provide clearer visibility on the key findings, outcomes and learning identified through Clinical Audit reports.  Whilst amendments to approved clinical audit plans should not be delayed as a result of timescales associated with the cycle of business, quarterly updates will include more detail on the changes to the approved plan including the rationale.  The review of minutes from QuEST committee which includes these findings, through four cycles of business will close this action.	Mar-26	Not Yet Due					Open	
159	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Claire Appleton, Assistant Director of Putting Things Right	Liam Williams		2022 - R3 (3.1)	<b>Mortality Reviews</b> The QuEST Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuEST Committee receives quarterly update reports to include:  3.1 the number of reviews undertaken, and the numbers of reviews required but not yet complete.	2022 - R3 (3.1)	The learning from deaths forum and associated sub groups Terms of Reference include the sharing of learning at a local level as well as contributing to learning on a national basis.  This information is shared via the Alert, Advise, Assure (AAA) highlight report. The content of the highlight report will be reviewed through governance processes to ensure consistency of reporting aligned to the Agendas of these fora.  Four highlight reports which include this consistency of data alongside QuEST committee minutes will close action 3.1	Dec-25	Met					Open	
167	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Hugh Bennett, Assistant Director of Commissioning & Performance	Liam Williams		2022 - RB (8.3)	<b>Quality Performance Reporting and Learning</b> We found that the QuEST Committee is well served with quality information, but there are opportunities for improvement. The Trust should:  8.3 work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits.	2022 - RB (8.3)	Whilst we remain limited by data accessibility we continue to pursue patient outcome data through ePCR as well as linking our critical systems to the Welsh Demographic Service allowing the first steps into linking remote clinical assessment with patient outcomes. The ability to achieve truly robust outcome measures without data linkage is limited, we continue to work with DHCW to resolve barriers to data sharing across NHS Wales.  Three Alert, Advise, Assure (AAA) Highlight reports from Information Governance Steering Group will provide evidence of this ongoing work and will close both action 8.3 and 8.4	Sep-25	Not Met	Dec-25		<u>25/26 Q2 Update:</u> 221025 (LT): Responsible Owner (HB) requested action remain open for further 3mths. Based on update supplied, 1st revised date (Dec25) applied  011025 (AK): Preliminary evidence provided: Information Governance Steering Group AAA Report to Executive Leadership Team for meetings held on 26 November 2024; 11 July 2025 and 22 September 2025  350925 (HB): ROSC reporting is now live at a health board level (linked to Purple go live) and various new clinical indicators for Emerg will come on stream in Q3, however, full data linkage is a national issue, which WAST cannot resolve on its own and is unlikely to be resolved over the next three months.	Open		
168	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Hugh Bennett, Assistant Director of Commissioning & Performance	Liam Williams		2022 - RB (8.4)	<b>Quality Performance Reporting and Learning</b> We found that the QuEST Committee is well served with quality information, but there are opportunities for improvement. The Trust should:  8.4 develop patient outcome measures to support its existing quality measures	2022 - RB (8.4)	Whilst we remain limited by data accessibility we continue to pursue patient outcome data through ePCR as well as linking our critical systems to the Welsh Demographic Service allowing the first steps into linking remote clinical assessment with patient outcomes. The ability to achieve truly robust outcome measures without data linkage is limited, we continue to work with DHCW to resolve barriers to data sharing across NHS Wales.  Three Alert, Advise, Assure (AAA) Highlight reports from Information Governance Steering Group will provide evidence of this ongoing work and will close both action 8.3 and 8.4	Sep-25	Not Met	Dec-25		<u>25/26 Q2 Update:</u> 221025 (LT): Responsible Owner (HB) requested action remain open for further 3mths. Based on update supplied, 1st revised date (Dec25) applied.  011025 (AK): Preliminary evidence provided: Evidence Provided: 1. Information Governance Steering Group AAA Report to Executive Leadership Team for meetings held on 26 November 2024; 11 July 2025 and 22 September 2025  25/09/25 (HB) ROSC reporting is now live at a health board level (linked to Purple go live) and various new clinical indicators for Emerg will come on stream in Q3, however, full data linkage is a national issue, which WAST cannot resolve on its own and is unlikely to be resolved over the next three months.	Open		
152	Audit Wales	23/24	FPC	Review of Cost Saving Arrangements	Chris Turley	Chris Turley	Medium	R3	The Trust should ensure that its savings reports to Board and F&PC, are consistent or provide a clear explanation of the differences between the reported savings performance. This will aid understanding, reduce confusion, and maintain the credibility of the Trust's savings reporting. (Paragraph 16).	R3	Finance Reports from MQ3 2024/25 to Trust Board and F&PC include further detailed analysis reporting of savings which includes split of recurrent and non-recurrent themes. WAST Monthly Monitoring Returns (MMR) submitted to WG also flow through committees and board. Further classification included in the proforma to be completed now include further breakdowns (i.e. Income Generation) so this allows clearer reconciliation for 2024/25 and beyond.	Aug-25	Met				<u>25/26 Q2 Update:</u> 160925 (JC) 25/26 savings schemes and the reporting of these now shows a variety of splits that are included in Finance Reports to committees and Board and hence this can now be closed. Evidence supplied to support closure.	Closed in Quarter	

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157	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Kate Blackmore, Assistant Director of Quality Governance	Liam Williams		84	<b>Duty of Candour and Quality Training</b> The Trust should take steps to increase compliance rates for duty of equality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements.	84	Access to both Duty of Quality and Duty of Candour training is available via ESR with Duty of Quality training also available via Learning@Wales.  It is important to balance not just the compliance to the training request but also the impact that training has.  In order to increase uptake rates the Duty of Quality training content has been duplicated onto Learn365 which allows the training to be more accessible and stress-free increasing uptake and engagement. Quality Management Group are now monitoring a similar approach for the Duty of Candour training.  Engagement with the training is monitored via the Education and Development Team as well as by the Quality Management Group. Local teams will receive regular updates on their compliance with this training and will receive support via QMG on how to improve uptake rates of training.  Highlight reports from QMG to CQGG which include the actions taken to increase uptake rates alongside the current completion rates across the organisation will close this action. This will be demonstrable through three Alert, Advise, Assure (AAA) Highlight reports.	Sep-25	Met				<u>25/26 Q2 Update:</u> 150925 (AK): Proposed for closure  Evidence supplied: 1. Quality Management Group AAA for Cycle 22 submitted to the Clinical & Quality Governance Group 12.6.25 (Ref 3.2) 2. Quality Management Group AAA for Cycle 23 submitted to the Clinical & Quality Governance Group 24.7.25 (Ref 4.2) 3. Quality Management Group AAA for Cycle 25 submitted to the Clinical & Quality Governance Group 29.9.25 (Ref 3.2)	Closed in Quarter
164	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Sara Mills, Head of Culture and Organisational Development	Liam Williams		2022 - R5	<b>Personal Appraisal and Development Reviews (PADR)</b> The Trust has low PADR compliance rates, for example in June 2022 the Trust's compliance was 59% against the 85% target. As part of embedding its new behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.	2022 - R5	We are implementing a range of measures aimed not only at increasing compliance but also at enhancing the quality and value of PADR conversations. The Trust is committed to improving PADR compliance while also ensuring that these reviews provide real value to staff and managers. We will continue to monitor progress and adjust our strategies as necessary, while also considering how our target metrics or measures of success can better reflect our commitment to meaningful and impactful conversations.  Minutes of People & Culture committee where updates are received regarding compliance to target and actions taken to improve the value to staff and managers across three cycles of business will close this action.	Dec-25	Met				<u>25/26 Q2 Update:</u> 150925 (AK): Proposed for closure  Evidence Supplied via Agenda and minutes from People and Culture Committees: November 2024 Meeting: Page 46 Ref P&C Metrics SBAR (Agenda) and Page 9 Ref 95/24 (Minutes) February 2025 Meeting: Page 105 Ref P&C Metrics SBAR (Agenda) and Page 13 Ref 130/24 (Minutes) May 2025 Meeting: Page 87 Ref P&C Metrics SBAR (Agenda) and Page 8 for minutes	Closed in Quarter
165	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Hugh Bennett, Assistant Director of Commissioning & Performance	Liam Williams		2022 - RB (8.1)	<b>Quality Performance Reporting and Learning</b> We found that the QuEST Committee is well served with quality information, but there are opportunities for improvement. The Trust should:  8.1 develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. measures	2022 - RB (8.1)	Through our Quality Performance Management Framework we will explore how we can draw focus across departments and directorates to triangulate information identifying themes for learning and improvement. This will be used either for internal continual improvement where this is within our boundaries or to share as part of external collaborative working both with health boards and commissioners. Committee	Sep-25	Met				<u>25/26 Q2 Update:</u> 151025 (AK): Proposed for closure  Evidence provided: 1. Quality, Patient Experience & Safety Committee minutes for 4 February 2025 2. Quality, Patient Experience & Safety Committee minutes for 9 May 2025  150925 (HB) The Monthly Quality & Improvement Report (MIQPI) provides 1200 indicators, using a balanced scorecard approach and inter-connected graphs and combination graphs. It provides a strong analytical tool for triangulation.	Closed in Quarter

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EA/2425-004	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R01	2023-R01	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru	2023-R01(a)	Make additions to Adverse Incident SOP so that responsibilities for QA upon closure of incident records is clear. Self assessment for each service area should be built into their Departmental Quality Performance Management Framework	Apr-25	Not Met	Mar-26	Open	<a href="#">25/26 Q1 Update:</a> 180625 (TT) Proposed revised date of March 2026 to ensure that all teams across the organisation have had an opportunity to undertake QA Self Assessment and ensure delivery of the QPMF Self Assessment in line with QPM Steering Group Workplan timelines. SOP updated and awaiting approval. QA Self Assessment Guidance has been reviewed and updated by QA Lead.	
EA/2425-005	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R01	2023-R01	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru	2023-R01(b)	Work with the Once for Wales Central Team to design listing reports which can be cascaded to service areas identifying records which need to be reprocessed and adjusted or additional information provided	Apr-25	Not Met	Sep-25	Mar-26	Open	<a href="#">25/26 Q2 Update:</a> 221025 (LT) 2nd Revised Date of Mar26 applied, therefore Executive Director of Quality and Nursing to be asked to attend ARAC on approval for recommended assurance. 250925 (AK) Propose a revised date of March 2026 due to capacity challenge; (sickness absence) within the Putting Things Right Team.
EA/2425-006	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R01	2023-R01	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru	2023-R01 (c)	Develop and deploy Robotic Process Automation to identify incomplete/ inappropriately completed records and report this information by exception report to the Quality Management Group to monitor performance.	TBA (Dependent on in year Digital priorities)	Not Yet Due		Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Scoping Meeting arranged with Assistant Director of Digital Services: Digital Transformation & Innovation for September 2025	
EA/2425-007	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R02	2023-R02	WAST should introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary	2023-R02(a)	Make additions to Adverse Incident SOP to ensure that timescales for reviewing new incidents, undertaking investigatory work and closing records is clear for all staff.	Apr-25	Not Met	Nov-25	Open	<a href="#">25/26 Q1 Update:</a> 180625 (TT) Proposed revised date of November 2025 to allow for further discussion at Data Governance Group on approvals for recommended timescales before SOP can be updated	
EA/2425-008	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R02	2023-R02	WAST should introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary	2023-R02(b)	Heads of Service to develop Improvement Strategies for incident closures which will be monitored through service focus area Quality Management Group	May-25	Not Met	Mar-26	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Proposed revised date of March 2026	
EA/2425-010	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R04	2023-R04	The process for obtaining consent for the release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.	2023-R04(a)	SOP to be reviewed for current accuracy and then approved by Senior Quality Team	Apr-25	Not Met	Dec-25	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Proposed revised date of December 2025	
EA/2425-011	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R04	2023-R04	The process for obtaining consent for the release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.	2023-R04(b)	Commence Quarterly Complaints Audit to provide assurance that SOP is being followed.	Jul-25	Not Met	Dec-25	Open	<a href="#">25/26 Q2 Update:</a> 250925 (AK) Propose a revised date of December 2025 to allow the team to undertake a full quarters audit	
EA/2425-013	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R06	2023-R06	It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach	2023-R06(b)	Senior Quality Team to undertake options appraisal of digital action planning software to enhance organisational assurance in respect of action plan completion	Sep-25	Not Met	Mar-26	Open	<a href="#">25/26 Q2 Update:</a> 250925 (AK) Proposed revised date of March 2026 due to staff sickness in the Putting Things Right Team.	
EA/2425-014	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R06	2023-R06	It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach	2023-R06(c) i	In order to set an achievable target within a continuous improvement journey, focus in the next year will be prioritised on how YCF are being utilised in NRI completion. This will include reviewing organisational investigation templates and provision of training to the Corporate Patient Safety team, to then be cascaded to NRI investigators in service areas.	Mar-25	Not Met	Mar-26	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Proposed revised date of March 2026	
EA/2425-015	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R06	2023-R06	It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach	2023-R06(c) ii	WAST to support workshop for OIWCMS Incident Workshop to provide enhanced definitions and guidance for YCF and ensure ambulance leaders can utilise it more confidently	Apr-25	Not Met	Mar-26	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Proposed revised date of March 2026	
EA/2425-016	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R09	2023-R09	WAST should ensure subject and sub-subject codes for all records in the Datix Cymru systems are completed consistently and comprehensively and are subject to validation checks	2023-R09	This recommendation was addressed through the development of a Complaints Validation SOP. The SOP has taken time to embed due to OCP and recruitment across the PTR & Legal Services Department.  Commence Quarterly Complaints Audit to provide assurance that SOP is being followed.	Jul-25	Not Met	Mar-26	Open	<a href="#">25/26 Q2 Update:</a> 250925 (AK) Proposed revised date of March 2026 due to staff sickness in the Putting Things Right Team.	
EA/2425-017	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R10	2023-R10	WAST should ensure the description field is completed correctly on the Datix Cymru system and that these are subject to validation checks.	2023-R10	This recommendation was addressed through the development of a Complaints Validation SOP. The SOP has taken time to embed due to OCP and recruitment across the PTR & Legal Services Department.  Commence Quarterly Complaints Audit to provide assurance that SOP is being followed.	Jul-25	Not Met	Mar-26	Open	<a href="#">25/26 Q2 Update:</a> 250925 (AK) Proposed revised date of March 2026 due to staff sickness in the Putting Things Right Team.	
EA/2425-018	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R01	R01	WAST to ensure that inclusion of additional contacts, where appropriate, is undertaken in relevant complaint records. An audit process may provide assurance of this.	R01	Training on why and how to attach additional contacts was provided by Central OIWCMS team in November 2024 as part of a day-long training offer to all of the Patient and Family Relations team on the use of the Feedback module.  Commence Quarterly Complaints Audit to provide assurance that training is being embedded in practice.	Jul-25	Not Met	Mar-26	Open	<a href="#">25/26 Q2 Update:</a> 250925 (AK) Proposed revised date of March 2026 due to staff sickness in the Putting Things Right Team.	
EA/2425-019	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R02	R02	WAST to undertake further training in relation to capturing reopened complaints in Datix Cymru.	R02	Training from the OIWCMS team included a section on how to manage Reopened complaints.  Commence Quarterly Complaints Audit to provide assurance that training is being embedded in practice.	Jul-25	Not Met	Mar-26	Open	<a href="#">25/26 Q2 Update:</a> 250925 (AK) Proposed revised date of March 2026 due to staff sickness in the Putting Things Right Team.	

EA/2425-020	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R03	WAST to consider noting a brief consideration of value on Datix Cymru at the outset of every stage of a complaint or claim.	R03	Develop a guidance flowchart to assess whether cases will breach the Redress threshold	Sep-25	Not Met	Mar-26	Open	<a href="#">25/26 Q1 Update:</a> 250925 (AK): Proposed revised date of March 2026 to ensure the SOP and Guidance flow chart is approved through the relevant governance routes
EA/2425-021	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R04	WAST to review the current exclusion from relevant complaint letters of standard paragraphs for Breach of Duty and Qualifying Liability	R04	WAST recognises the potential for changes to the approach around how legal information is provided to complainants as part of the revised PFR Guidance and Concerns Regulations.  WAST will review the information it provides on Breach of Duty and Qualifying Liability within its complainants responses. A review paper will be drafted for the Executive Team due to the statutory requirement for this information to be provided.	Apr-25	Not Met	Oct-25	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Proposed revised date of October 2025
EA/2425-022	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R05	WAST should ensure Quantum fields in Datix Cymru are completed within Redress records	R05	This is now being completed on every case.  Development of QA dashboard in Datix to monitor field completion.	Apr-25	Not Met	Dec-25	Closed in Quarter	<a href="#">25/26 Q1 Update:</a> 241025 (AK) Proposed for closure.  Evidence provided: Report demonstrating that there are estimated (quantum) figures in all confirmed ongoing Redress cases
EA/2425-023	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R06	WAST to consider developing a record of settlements to assist and advise other colleagues of previous decisions.	R06	Repository in shared folder to be created using Data listing report of past cases	Sep-25	Met		Closed in Quarter	<a href="#">25/26 Q1 Update:</a> 250925 (AK): Proposed for closure.  Evidence provided: 1. Screenshot of shared folder in Teams 2. Record of CCP settlement
EA/2425-024	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R07	WAST should ensure the Management of Compensation Claims Policy is updated and subject to periodic reviews	R07	WAST recognises the potential for changes as part of the revised PFR Guidance and Concerns Regulations.  Policy has been drafted but needs to be placed into appropriate template, track changes, consultation with TU and rescheduled for Policy Group.	Dec-25	Not Yet Due		Open	.
EA/2425-025	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R08	WAST to continue to increase its use of the Datix Cymru system for the management of matters utilising the current stage and claim details fields as much as possible	R08 (a)	Designate the fields that require completion to provide clarity to staff.	Feb-25	Not Met	Jan-26	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Proposed revised date of January 2026
EA/2425-026	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R08	WAST to continue to increase its use of the Datix Cymru system for the management of matters utilising the current stage and claim details fields as much as possible	R08 (b)	Development of QA dashboard in Datix to monitor field completion.	Apr-25	Not Met	Mar-26	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA): Proposed revised date of March 2026
EA/2425-027	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R08	WAST to continue to increase its use of the Datix Cymru system for the management of matters utilising the current stage and claim details fields as much as possible	R08 (c)	Development of regular BI report to provide assurance		Not Yet Due		Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Dependent on IDS prioritisation
EA/2425-028	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R09	WAST to update the flowchart for the management of requests and police information requests	R09	Inquest Management SOP to be developed to supersede Rowchart (Police information requests are now managed by Records)	May-25	Not Met	Dec-25	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Proposed revised date of December 2025
EA/2425-029	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R10	WAST to continue to increase its use of the Datix Cymru system with regards to inquest matters to include the fields for both current stage and statements.	R10 (a)	Designate the fields that require completion to provide clarity to staff.	Mar-25	Not Met	Oct-25	Open	<a href="#">25/26 Q1 Update:</a> 250925 (AK): Proposed for closure.  Evidence supplied: Spreadsheet of the 'current stages' for coroner and Inquest cases
EA/2425-030	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R10	WAST to continue to increase its use of the Datix Cymru system with regards to inquest matters to include the fields for both current stage and statements.	R10 (b)	Development of QA dashboard in Datix to monitor field completion	Apr-25	Not Met	Oct-25	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Currently in testing phase. Proposed revised date of October 2025
EA/2425-031	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R10	WAST to continue to increase its use of the Datix Cymru system with regards to inquest matters to include the fields for both current stage and statements.	R10 (c)	Development of regular BI report to provide assurance		Not Yet Due		Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Dependent on IDS prioritisation
EA/2425-032	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R11	WAST to update the Learning from Event Report Standard Operating Procedure to reflect the new process that is being implemented.	R11	Management of LFERs has transferred from Legal Services to Patient Safety team under OCP arrangements. It is anticipated that this will bring significant benefits in terms of more timely and comprehensive completion, although 'legacy' cases may still present some challenges during the transition period. A SOP is under development as part of the new arrangements.  SOP to be finalised & approved by SQT	Apr-25	Not Met	Oct-25	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Currently in testing phase. Proposed revised date of October 2025
EA/2425-033	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R12	WAST to fully utilise the Datix Cymru System for the tracking of both Learning from Event Reports and Case Management Report submission deadlines and the introduction of an assurance and tracking process to offer visibility to this.	R12 (a)	Designate the fields that require completion to provide clarity to staff.	Mar-25	Not Met	Jan-26	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Proposed revised date of January 2026
EA/2425-034	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R12	WAST to fully utilise the Datix Cymru System for the tracking of both Learning from Event Reports and Case Management Report submission deadlines and the introduction of an assurance and tracking process to offer visibility to this.	R12 (b)	Development of QA dashboard in Datix to monitor completion	Apr-25	Not Met	Mar-26	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA): Proposed revised date of March 2026
EA/2425-035	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams		R12	WAST to fully utilise the Datix Cymru System for the tracking of both Learning from Event Reports and Case Management Report submission deadlines and the introduction of an assurance and tracking process to offer visibility to this.	R12 (c)	Development of regular BI report to provide assurance		Not Yet Due		Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Dependent on IDS prioritisation

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EA/2526-001		2024/25	PPC	UEC Arrangements for Managing Demand WAST (April 2025) AW		Director of Digital	Director Digital		R1	<b>Accuracy of 111 Website</b> To ensure information used to signpost patients to urgent and emergency services are accurate, the Trust should work with partners to review and replace any out-of-date or misleading information on the 111 Wales website, for example, the NHS Direct Wales phone number (Paragraph 28).	R1	The Trust accepts this recommendation. While WAST is not directly commissioned to manage the 111 Wales website, we fully support the need for accurate content to signpost patients safely. We routinely raise concerns, such as outdated references to NHS Direct Wales and will strengthen this by formally escalating issues through an agreed assurance route with Digital Health and Care Wales.  A business case has been drafted to propose a new governance model with dedicated resources for oversight and content management to improve accuracy and ownership regarding financial envelopes and commissioner expectations, which are prerequisites to formal submission.  Website content accuracy will be a standing item at the monthly 111 Wales Digital Governance Group. Over the next 12 months, issued will be actively monitored, and formal escalations logged to demonstrate progress and provide evidence of action taken.	May-26	Not Yet Due			Open	
EA/2526-002		2024/25	PPC	UEC Arrangements for Managing Demand WAST (April 2025) AW		Director of Digital	Director Digital		R2	<b>Directories of Services</b> To ensure the Trust has access to accurate and up-to-date information on health board services it should work with health boards to identify leads for maintaining the directories (Paragraph 46).	R2	The Trust accepts this recommendation. We agree on the need for accurate and up-to-date service information. While WAST does not control the content provided by health boards, we maintain mechanisms to receive and manage this data. The recommendation is therefore best addressed through strengthened collaboration with health boards, who remain responsible for the accuracy of their service information.  A business case has been drafted to improve Directory of Services (DoS) governance and support. Discussions with Welsh Government are ongoing regarding financial envelopes and commissioner expectations, which are prerequisites to formal submission.  WAST will continue to update any content we own/publish into the DoS and will escalate outdated information to relevant health boards. This will be monitored over 12 months, with escalations logged as evidence of action.	May-26	Not Yet Due			Open	

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596	22/23	Audit	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	1.1	Following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements	1.1	Accepted. Formal risk appetite statements will be developed in conjunction with the transformational BAF in 23/24; however, the risk consequence matrix is in place and includes risk appetite across a range of categories. The Trust sets out its risk appetite for patient harm in its annual report. This action forms part of the risk management transformation programme monitored at the Strategic Transformation Programme Board. Additionally, a Board Development Session is planned for February 2024.	Jun-24	Not Met	Mar-25	Jul-25		Closed in Quarter	<a href="#">25/26 Q2 Update</a> 981025 (18): Action proposed for closure. All six Risk Appetite Statements (RAS) considered at Board Development Day (BDD). These will be presented to the Trust Board on 27/11/25 for formal approval, and the implementation plan is on the Audit Risk and Assurance Committee (ARAC) agenda for 02/12/25.