Bundle Reading Room 2 March 2026

08 Risk Management and Board Assurance Framework
- Item 08 Annex 4 - BAF 191125 v1.1 JB

11 Audit Tracker
- Item 11 Annex 1 Audit Tracker 3.0 - Internal Audit Q3 Updates (All)
- Item 11 Annex 2 Audit Tracker 3.0 - External Audit Q3 Updates (All)

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	28/10/2025	TREND	OVERALL 20 (4x5)
			Date of Next Review:	28/11/2025	⬇	

IF	**THEN**	**RESULTING IN**
significant internal and external system pressures continue	there is a risk of an inability and/or a delay in ambulances reaching patients in the community	patient harm and death

	External (LxC)			Internal (LxC)		
Inherent	TBC	TBC	TBC	TBC	TBC	TBC
Current	TBC	TBC	TBC	TBC	TBC	TBC
Target	TBC	TBC	TBC	TBC	TBC	TBC

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

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.

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.

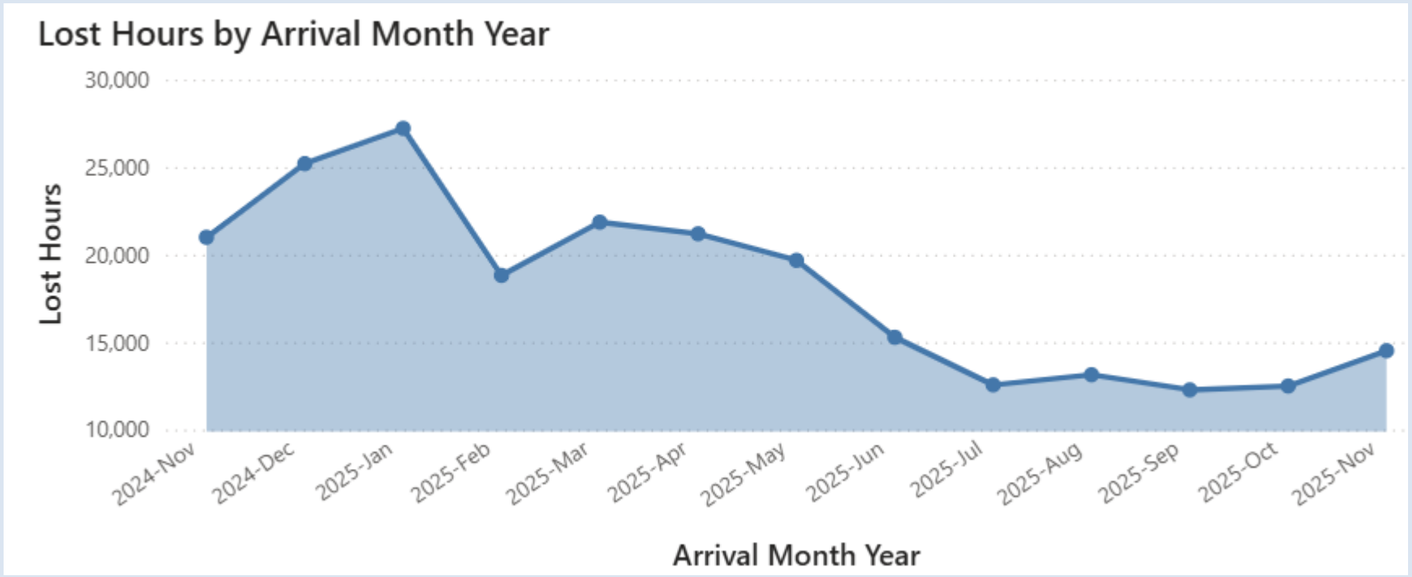
The next steps will include testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death.

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.

EXECUTIVE OWNER	Executive Director of Operations	**ASSURANCE COMMITTEE**	Quality, Safety and Patient Experience Committee

Risk Commentary



Whilst the risk **score has reduced slightly from 25 (5x5) to 20 (4x5) it** still reflects the impact of ambulance handover delays at Emergency Departments and timely access to definitive care. The strategic implications for the Trust **remain** 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 **and two** of the Trust's Clinical Transformation Model - specifically the new performance framework - have 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 *45* **minute release (45MR)** 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. **In recent weeks, however, we have seen a deterioration in 45MR compliance in those areas such as Swansea Bay that had seen improvement previously and a recent increase in hospital delays is also representative of pressure across the secondary care system.**

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	28/10/2025	TREND	OVERALL 20 (4x5)
		Date of Next Review:	28/11/2025	⬇	

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 **45MR from 1 October was a partially accepted MAG recommendation. There continues to be a determination from NHS P&I for this to be the standard, with Health Boards being required to adopt this by the end of January 2026 and replicate the best month of October, November or December 2025.** The efforts made by the majority of Health Board in the **proceeding** months is a welcome step. Several sites, including BCU however continue to be problematic with **45 MR** improvements not yet realised. **In recent weeks we have seen a deterioration in 45MR compliance in those areas such as Swansea Bay that had seen improvement previously and a recent increase in hospital delays is also representative of pressure across the secondary care system.**

CONTROLS	ASSURANCES		
MONITOR – External	External ***Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.***		
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. The introduction of **45MR** from 1 October and the efforts made by the majority of Health Boards in the **proceeding** 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.		
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.		
3. Mitigating Avoidable Harm Actions	3. 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.		
4. Sustainability of 45 MR in Cardiff and Vale, Cwm Taf and Swansea Bay	**4. Performance data confirms that Cwm Taff Morgannwg are consistently meeting the 45MR target. Ongoing regular performance reviews, and exception reporting will provide continued assurance that compliance will be maintained throughout the winter period.**		
MITIGATE - Internal ***How do we know the controls are effective. How will these impact the target risk score?***	Internal ***over the three lines of assurance. How do we know the assurances are effective*** ***Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk***		
Control 1 – Policies/SOPs 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).	**First Line of Assurance** Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly Performance, Demand and Capacity meetings to review REAP levels.	**Second Line of Assurance** ODU dashboards, Performance Demand and Capacity performance metrics data and DATIX and compliance reporting to the COO's.	**Third Line of Assurance** Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System Audit received June 25, actions being worked through.
Control 2 – Performance/Tactics	**First Line of Assurance** Daily conference calls (National Huddle) to agree RE levels in	**Second Line of Assurance** ETA dashboard, UHP reporting in local and business meetings. ODU dashboards, Performance Demand and Capacity performance metrics data,	**Third Line of Assurance**

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	28/10/2025	TREND	OVERALL 20 (4x5)
		Date of Next Review:	28/11/2025	↓	

ETA Scripting, CCC Emergency Rule, Red call performance, Transfer of Care, ARA (Swansea and YGC), EMS Demand and Capacity Review.	conjunction with health boards, weekly Performance, Demand and Capacity meetings to review REAP levels. Local Business Meetings performance discussions.	MIQPR (Monthly Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly).	Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System Audit received June 25, actions being worked through.
Control 3 – Operational Activities National Risk Huddles, Performance, Demand and Capacity meetings, WAST Serious Clinical Incident Forum (SCIF), Operational Handover Group	**First Line of Assurance** Daily Risk Huddles, Weekly Performance Demand and Capacity Meetings, Local business meetings.	**Second Line of Assurance** Patient safety highlight reports. ODU Dashboards, Performance, Demand and Capacity performance metrics, MIQPR (Monthly Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly**). Interim Medium Term Plan (IMTP)**	**Third Line of Assurance** Ministerial Advisory Group, NHS Exec Handover Group, Audit Wales investigation of Urgent and Emergency Care System. Audit received June 25, actions being worked through.
Control 4 – Resources 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.	**First Line of Assurance** CSP review and escalation, On Call team start and end of shift, Performance, Demand and Capacity Meetings, Senior Leadership Team meetings.	**Second Line of Assurance** Shift reports, CSP review, On Call rota review, APP Dashboard, Volunteer performance highlight reporting.	**Third Line of Assurance** Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System. Audit received June 25, actions being worked through.
Control 5 – Clinical Model Transformation (CMT) Consult and Close (including Mental Health Practitioners), Clinical review of code sets, Remote Clinical Support, Rapid Clinical Screening, expansion of See and Treat resources.	**First Line of Assurance** CPAS, DCR and CQGG Meetings, Clinical Model Transformation Project Board. Senior Leadership Team Meetings. Performance, Demand and Capacity Meetings.	**Second Line of Assurance** Performance, Demand and Capacity metric reporting, CPAS/DCR reporting, Volunteer highlight reporting, clinical model transformation highlight report.	**Third Line of Assurance** Audit Wales investigation of Urgent and Emergency Care System. Audit received June 25, actions being worked through.

GAPS IN CONTROLS	GAPS IN ASSURANCE
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. The **45 MR** initiative, once embedded across all Health Boards, will help support to address this gap.
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.
4. Inconsistent pathways across Health Boards	4.
5. Local Delivery Units – Hywell Dda and BCU	5. 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.
6. Ministerial Advisory Group (MAG)	6.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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	28/10/2025	TREND	OVERALL 20 (4x5)
		Date of Next Review:	28/11/2025	⬇	

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.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner (Internal only)	Completion / Milestone date	Progress Update
1. 6 weeks test of change Morriston	Sonia Thompson, Assistant Director of Operations	**COMPLETE**	OCT25 – Test of change now moved to BAU, discussions will be started within Swansea Bay to explore W45 options similar to Cardiff and Vale. 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. 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.
2. Royal Glamorgan working to 45 minute handover	Sonia Thompson, Assistant Director of Operations	**COMPLETE**	OCT25 – No progressional update however the 2 CTM sites are still performing well in relation to Notification to Handover Performance. 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 Jun 25 – Handovers with average of 30 mins. Current ongoing discussion to rollout trial in other areas.
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		**OCT25 - The Clinical Model Transformation (CMT) Programme continues to advance the modernisation of care delivery through the introduction of new 999 call categories, aligned to the 12-month pilot of the new Ambulance Performance Standards. The implementation of these categories is phased, with Phase 1 commencing in July 2025 and Phase 2 in December 2025. These changes represent a significant step towards a more outcomes focused and patient centred model of emergency care. Further detail and supporting rationale are available through CMT Programme reporting.** 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.
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 This will be assigned an operational colleague.	**COMPLETE**	**July25 –** 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. Jun 25 – Awaiting report from Audit Wales May 25 – Awaiting report from Audit Wales which will come through Audit Committee.
5. **Ongoing monitoring of the 45MR to continue through the winter to ensure consistent delivery**	**Sonia Thompson, Assistant Director of Operations**		

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:	29/12/2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	29/01/2026	➡	

IF	THEN	RESULTING IN
patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	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	patients coming to significant harm and a poor patient experience

	External (LxC)			Internal (LxC)		
Inherent	TBC	TBC	TBC	TBC	TBC	TBC
Current	TBC	TBC	TBC	TBC	TBC	TBC
Target	TBC	TBC	TBC	TBC	TBC	TBC

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

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 has been embedded.

Testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken is underway. 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.

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.

EXECUTIVE OWNER	Executive Director of Quality and Nursing	ASSURANCE COMMITTEE	Quality, Patient Experience and Safety Committee

This risk remains at the highest level despite early indications of improvement in some areas, performance remains variable across Wales and handover delays continue to present a high risk of patient deterioration, harm and poor experience, with ongoing regulatory and public scrutiny.

The Trust has a well-established internal control environment, including real time operational and clinical oversight, escalation and release processes, and structured clinical governance. Phase 1 and Phase 2 of the Clinical Model Transformation (CMT) Programme have now gone live, representing an important step in aligning response, triage and clinical decision-making to patient acuity and workforce capability.

However, it is too early to determine whether these changes have delivered sustained or system-wide risk reduction, and the risk score has therefore been maintained. Internal controls cannot fully mitigate external system constraints, including Emergency Department capacity, patient flow and inconsistent delivery of national handover standards. Continued engagement with national and regional programmes, including Six Goals and Wait 45, remains essential to support improvement. Until sustained, evidenced system-wide improvement is demonstrated, the risk remains above target and appropriately sits on the Board Assurance Framework. The impact on staff wellbeing is recognised and is managed through the linked workforce risk (Risk 558).

CONTROLS	ASSURANCES
MONITOR - External	External - ***Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.***
1. **Welsh Health Circular WHC/2024/041: NHS Wales Hospital Handover Guidance (15-minute standard)** National handover standard representing an external system control, with delivery and compliance led by Health Boards. **Internal Monitoring** Real-time oversight via ODU and Clinical Safety Plan for extended handover delays. Handover performance monitored through routine performance and quality governance reporting.	**External Monitoring / Assurance** • Oversight through Welsh Government, including Six Goals and Joint Commissioning arrangements. • Independent scrutiny via national audit and regulatory inspection.
2. **Six Goals for Urgent and Emergency Care Programme** • National system oversight of urgent and emergency care performance, including ambulance handover.	2. External performance assurance through Welsh Government oversight arrangements, including Six Goals and NHS Wales escalation frameworks.
3. **NHS Wales Performance Framework 2024-25** External monitoring of ambulance handover performance through national performance measures.	External assurance through NHS Wales performance oversight and escalation arrangements.

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:	29/12/2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	29/01/2026		

4. **NHS Wales Quality and Safety Framework and Duties of Quality and Candour** External assurance through NHS Wales quality, safety and candour frameworks.	Statutory reporting and external assurance through Duties of Quality and Candour, supported by national quality and safety monitoring.		
5. **Nationally led operational escalation responses** External system escalation arrangements to manage periods of sustained pressure.	Assurance through national operational oversight, escalation and review arrangements.		
MITIGATE - Internal ***How do we know the controls are effective. How will these impact the target risk score?***	Internal ***over the three lines of defence. How do we know the assurances are effective*** ***Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk***		
Control 1: Policies / SOPs / Resources • Regional Escalation Protocol, Immediate Release Protocol, Resource Escalation Action Plan (REAP) and Clinical Safety Plan (CSP). These controls are embedded as business-as-usual and provide a consistent approach to managing clinical and operational risk during periods of handover delay. Effectiveness is demonstrated through routine escalation, oversight and governance reporting, providing assurance that risk is actively managed. While these controls strengthen internal risk mitigation, they do not, in isolation, reduce the overall risk score, which remains dependent on external system performance.	**First Line of Assurance (Operational)** Real-time operational and clinical oversight through routine escalation and application of agreed escalation and safety protocols.	**Second Line of Assurance (Internal Monitoring)** Review of handover-related risk and mitigation through internal performance and quality governance reporting, including senior operational and clinical forums.	**Third Line of Assurance** Independent scrutiny through external audit, regulatory review and national oversight arrangements.
Control 2: Clinical Guidance for staff • Trust-approved clinical guidance and notices to support safe clinical decision-making for patients experiencing delayed handover. This guidance provides a consistent framework for managing clinical risk and escalation during periods of handover delay and is embedded within routine clinical practice. It supports timely identification and escalation of deterioration and reinforces professional accountability within agreed scopes of practice. While this control strengthens clinical safety and mitigates the risk of unmanaged harm, it does not, in isolation, reduce the overall risk score, which remains dependent on system-wide factors outside the Trust's direct control.	**First Line of Assurance (Operational)** Application of clinical guidance and escalation requirements within routine clinical practice.	**Second Line of Assurance (Internal Monitoring)** Review of handover-related clinical incidents, escalation and learning through internal patient safety and clinical governance reporting.	**Third Line of Assurance** External scrutiny through regulatory review and national oversight, including MAG.
Control 3: Clinical Governance mechanisms • Established clinical governance mechanisms to review learning from patient safety incidents, concerns and mortality related to delayed handover. These mechanisms provide assurance that patient harm associated with delayed handover is identified, reviewed and escalated appropriately, with learning shared internally and, where relevant, with Health Boards to support system improvement. Clinical oversight ensures learning informs risk mitigation and governance decision-making. This control strengthens organisational learning and assurance but does not, in isolation, reduce the overall risk score, which remains dependent on wider system performance.	**First Line of Assurance (Operational)** Identification and escalation of incidents, concerns and mortality cases through established patient safety processes.	**Second Line of Assurance (Internal Monitoring)** Review and oversight through clinical governance forums, including SCIF and CAG.	**Third Line of Assurance** External scrutiny through regulatory review, national oversight and Ministerial Advisory Group (MAG) arrangements.
Control 4: Implementation of Duty of Quality, Candour & Quality Standards • Implementation of statutory Duties of Quality and Candour through established internal quality governance arrangements. This control provides assurance that patient harm associated with delayed handover is identified, reviewed and addressed in line with statutory requirements, with appropriate openness and accountability. It supports organisational learning and quality improvement during periods of operational pressure.	**First Line of Assurance (Operational)** Identification and reporting of harm in line with statutory duties and internal quality processes.	**Second Line of Assurance (Internal Monitoring)** Oversight through internal quality and safety governance arrangements.	**Third Line of Assurance** Welsh Government assurance through Duty of Candour/Duty of Quality annual reporting. Statutory reporting and external assurance through Welsh Government, regulatory oversight and MAG arrangements.

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:	29/12/2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	29/01/2026		

While this control strengthens internal assurance and transparency, it does not, in isolation, reduce the overall risk score, which remains dependent on wider system performance.			
Control 5: Clinical Model Transformation (CMT) • Implementation of the Clinical Model Transformation (CMT) to improve clinical triage, decision-making and demand management. CMT provides an internal control to reduce avoidable conveyance, improve early clinical intervention and support more appropriate use of ambulance and hospital resources. It strengthens the Trust's ability to manage risk associated with demand and delayed handover, but its impact on the overall risk score is dependent on sustained system-wide improvement.	**First Line of Assurance (Operational)** Operational delivery of the Clinical Model Transformation and associated clinical pathways.	**Second Line of Assurance (Internal Monitoring)** Programme oversight and performance review through established transformation, operational and quality governance arrangements.	**Third Line of Assurance** External scrutiny through national oversight, performance review and MAG arrangements.
Control 6: Integrated Medium-Term Plan (IMTP) • **Alignment of IMTP 2025–27 priorities and deliverables with Corporate Risk 224.** **This control provides strategic assurance that mitigating actions for handover delays are reflected within the Trust's medium-term planning and delivery framework. It supports prioritisation and resourcing of actions but does not, in isolation, reduce the overall risk score.** **NEW Control – completed Action 29/12/25**	**First Line of Assurance (Operational)** **Delivery of IMTP actions aligned to agreed priorities.**	**Second Line of Assurance (Internal Monitoring)** **Oversight of IMTP delivery through established planning and performance governance (STB).**	**Third Line of Assurance** **External scrutiny through Welsh Government IMTP assurance and performance review arrangements (F&PC).**

GAPS IN CONTROLS	GAPS IN ASSURANCE
External	External
1. Inconsistent compliance by Health Boards with national handover standards, limiting WAST's ability to mitigate the risk through internal controls alone.	1. Limited independent assurance on the implementation and effectiveness of Health Board handover improvement actions, resulting in variable confidence in system-wide impact.
2. Ongoing Emergency Department and inpatient capacity pressures limit consistent delivery of national handover standards by Health Boards.	2. Limited independent assurance on how Health Boards are addressing Emergency Department and inpatient capacity pressures that impact ambulance handover performance.
Internal	Internal
1. Limited ability to independently validate the effectiveness of Health Board actions arising from handover-related harm cases shared by WAST.	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. Limited independent assurance on the effectiveness of Health Board actions arising from joint investigations into delayed handover harm; assurance is largely reliant on Health Board feedback. This gap may be strengthened through Audit Wales and MAG oversight.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner (Internal only)	Completion / Milestone date	Progress Update
1. Contribution to the development of a national joint investigation learning repository	Assistant Director of PTR	Q1 2026	Pilot completed with Cardiff and Vale UHB. Evaluation concluded (Sept 2025). National roll-out agreed and to be progressed through the Once for Wales Concerns Management Programme.
2. Delivery and evaluation of the Clinical Model Transformation (CMT)	Assistant Director of Operations, Integrated Care	Q2 2026	Phase 1 go-live completed (July 2025). Phase 2 go-live completed (November 2025). Public communications issued. Programme delivery and evaluation ongoing. Impact on handover risk to be assessed through programme evaluation and system performance data.
3. Audit Wales review of the urgent and emergency care system	Executive Director of Operations	May 2025 (report received); implementation ongoing	Audit Wales recommendations are being taken forward through agreed system and Trust governance arrangements, with delivery led by the Executive Director of Operations and oversight through ELT and the Board.

REPUTATIONAL RISKS TO BE INSERTED IN THIS SECTION IN THE NEXT ROUND – MARCH 2026.

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:	28/10/2025	TREND	20 (4x5)
		Date of Next Review:	28/11/2025	➡	

IF	THEN	RESULTING IN
the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared	there is a RISK that the Trust's Incident Response will be suboptimal	avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability.

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	4	5	20
Target	2	3	6

IMTP Deliverable Numbers:

Strategic Objective:

EXECUTIVE OWNER	Executive Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary

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.

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.

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:

- **R106 Capability Report**
- **Capability to Prepare**
- **Capability to Respond**
- **Capability of Specialist Assets**

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.

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.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Forty-six (46) 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.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Two (2) outstanding MAI Recommendations, identified as pertinent to WAST by the self-assessment, require action against to implement the associated learning **(REF: MAI recommendations** 26 & 88). 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:	28/10/2025	TREND	20 (4x5)
		Date of Next Review:	28/11/2025	➡	

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	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. 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.
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	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. 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. 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. Oct25 – A series of scrutiny sessions with Commissioners has been undertaken, the most recent being in September 2025. The **original timescales to respond to the** Commissioner **November 2025** has **been extended by 1-month to December 2025.**
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	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. 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 & Exercising Team have established, they will then need to provide sufficient levels of exercising to comply with the exercising-related MAI recs).

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	➡	

IF	THEN	RESULTING IN
there are high levels of absence e.g., sickness and alternative duties.	there is a risk that there is reduced resource capacity	an inability to deliver services which adversely impacts on quality, safety, and patient/staff experience

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	4	4	16
Target	3	4	12

IMTP Deliverable Numbers: 13, 14, 15, 22, 24, 25, 26

Strategic Objective:

EXECUTIVE OWNER	Director of People	ASSURANCE COMMITTEE	People and Culture Committee

Risk Commentary

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.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
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

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	➡	

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
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. Support by PS project lead with relevant PS team then supporting line managers and tracking actions on longest absence cases	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

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	➡	

36 Development of a refreshed stress risk assessment is underway. This will be relaunched with managers when completed	**Source of assurance to be identified**		
	Independent Assurance (3rd Line of Assurance)		
	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		
GAPS IN CONTROLS	**GAPS IN ASSURANCE**		
(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		
Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
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 **revised date 31.03.26**	Data analyst appointed in Workforce Planning team who will look at sickness data and reporting opportunities at a local level
3. Analyse link between hot spots and the culture in these areas to address cultural issues	AD for Culture, Inclusion & Wellbeing	31.03.2025 **revised date 31.12.2025**	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. Tracking of flexible working requests has seen an increase in requests and approvals, especially within operations.
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 **Revised date 31.12.25**	Yet to start due to other key projects and task and finish groups underway. Also linked to overrun work.
7. Develop the team around the person model / individual support network	Deputy Director of People and Culture	31.03.2025 **Revised date 13.12.25**	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 **30 November 2025**	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:	04/12/2025	TREND	16 (4x4)
		Date of Next Review:	04/01/2026	➡	

IF	THEN	RESULTING IN
there is a lack of resources and available technology and infrastructure	there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	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

Risk Commentary

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 **now received but discussion is required on the Trust response, the next steps, and the resources requried to further progress this. It should be noted that as work in this space increases, so too does the volume of BAU management required e.g. on the development of EV charging infrastructure, the Trust now has an EV Network which needs to be formally managed (contract management with suppliers, remedial action on faults, warranty renewal, liaison with suppliers, use of network and prevention of fraudulent use, reporting on charging capacity used, financial implications etc).**

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
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 January 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. Ambitions for further decarbonisation of fleet to be included in 2026/27 Business Justification Case (**approved by Trust Board on 27th Nov and submitted to WG on 28th Nov 2025)**
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.

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	04/12/2025	TREND	16 (4x4)
		Date of Next Review:	04/01/2026	➡	

External - Independent Assurance:

- Sustainability section in Annual Report audited by Internal Audit. Annual audits by BSI on accreditation

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. 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. **To note, as the Trust further implements infrastructure, there is a greater BAU workload which the team is currently not resourced to manage. With the development of EV charging infrastructure, the Trust now has an EV Network which needs to be formally managed (contract management with suppliers, remedial action on faults, warranty renewal, liaison with suppliers, use of network and prevention of fraudulent use, reporting on charging capacity used, financial implications etc)**
2. 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.
3. 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. **Further Executive level and Trust Board discussion will be required on the Trust response to the new SDP, and the ability for the Trust to resource this appropriately. Given the developmental nature of this work, it is now not possible to sustain the current governance, infrastructure, progress without additional resource.**

Risk ID 671	Unauthorised or Inappropriate use of AI technologies	Date of Review:	02/12/2025	TREND	16 (4x4)
		Date of Next Review:	19/01/2026	➡	

IF	THEN	RESULTING IN
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	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	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

EXECUTIVE OWNER	Director of Digital	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary

The current risk is high due to the appetite of WAST to adopt new AI technologies, 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 **currently** limited guidance and regulation offered in this sector for health & care providers.

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.

An AI Steering Group (AISG) has been established, reporting into Information Governance Steering Group, which already has delegated authority from the Executive Leadership Team, and provides AAAs monthly, and additional reporting for assurance through to Finance & Performance Committee. The AISG met for the first time in October 2025, and again in November, and will continue monthly with a regular cycle of business including oversight of existing tooling, projects and implementations, advice on strategic alignment of future use cases, and responsibility to support the development of guidance and frameworks to ensure the approach of "responsible AI" across the Trust.

CONTROLS	ASSURANCES
1. Guidance & Awareness a) Gen-AI guidance + Engagement sessions (small audience) b) **Procurement toolkit**	1. Guidance & Awareness a) **Gen-AI guidance issued to all WAST (January 2025); Copilot guidance issued to Copilot licence holders (as onboarded to the pilot);** Copilot Pilot feedback form **b) Toolkit for Procurement of AI in health and social care sector in Wales (v1.2 2025), has been published by the AI Working Group of Health & Social Care in Wales, 2025.**
2. Strategic Alignment a) IMTP reference to use cases	2. Strategic Alignment a) AI safety and adoption updates reported via Digital Report to Finance & Performance Committe bi-monthly 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 & Performance Committee bi-monthly.
3. Technical Controls a) Digital issued and managed Copilot licences (and pilot) b) Deactivation of licences not regularly used	3. Technical Controls a) Monitoring of Copilot users via MS Purview b) Copilot pilot evaluation feedback allows scrutiny of use cases and applications at regular intervals
4. Processes a) Cyber Assurance of suppliers during procurement processes through existing mechanisms e.g. cyber essentials b) Data Protection related to AI projects / tools covered by existing DPIA c) Alignment with NHS Wales guidance and position including e.g. procurement routes	4. Processes a) Cyber risks and Data Protection logs reported to IGSG. b) Monitoring of Datix incidents related to data breaches and security
5. Expertise a) Ability to draw on Digital expertise for advice (including data science, algorithmic, cyber, data protection, data quality and other relevant domains)	5. Expertise a) AI risks and issues informally reported via IGSG to date in lieu of dedicated forum b) -

Risk ID 671	Unauthorised or Inappropriate use of AI technologies	Date of Review:	02/12/2025	TREND	16 (4x4)
		Date of Next Review:	19/01/2026	➡	

b) Leverage support from existing suppliers with technical expertise (e.g. Microsoft) c) **AI Steering Group established to advise and guide on AI-related decisions and progress**	c) First meeting of monthly AISG occurred in October 2025, with AAA to be shared at next meeting of IGSG, and routinely thereafter.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Guidance & Awareness a) Copilot rollout and chat requires guidance for all WAST staff b) General awareness sessions / e-learning for all WAST staff **c) Ethics and responsible AI frameworks**	1. Guidance & Awareness a) eLearning compliance **b) Pulse check or other mechanism to understand staff views on AI** c) **Approval and monitoring of any developed or adopted frameworks by AISG and IGSG**
2. Strategic Alignment 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)	2. Strategic Alignment 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) 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)

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**; in agreement with Policy Group this has been deferred until February meeting to allow inclusion of recent guidance and external policy updates.**
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. Awareness campaign (including ethics, DP, shadow IT risks)	Leanne Smith	Q1 26/27	To be managed by AISG
4. Board Development Day and AI Mission Statement development with Trust Board	Leanne Smith	February 2026	
5. Copilot rollout to avoid ChatGPT risk – requires usage monitoring mechanism	Aasha Cowey	June 2026 (current pilot licences run until this time	Dependent on funding **Dec-25: copilot pilot evaluation underway, and decision to be made on reallocation of unused licences and associated process.**
6. Alignment with WG and NHS Wales AI policy positions	Leanne Smith	Q4 25/26	Proactively engage with WG AI Commission
7. eLearning for all staff	**Leanne Smith**	Q4 25/26	Supported by AISG

Risk ID 671	Unauthorised or Inappropriate use of AI technologies	Date of Review:	02/12/2025	TREND	16 (4x4)
		Date of Next Review:	19/01/2026	➡	

			Dec-25: AISG to support Digital Learning Manager (Education & Development team) in development of AI e-learning module. Leanne Smith as Chair of AISG to be responsible for updates on this action.
8. 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
9. WG AI Commission membership / alignment	Leanne Smith	Q3 25/26	Proactively engage with WG and NHSW AI groups **Dec-25: Welsh Government are redesigning the AI Commission, and considering membership (likely to include Directors of Digital). An AI policy and plan is also in draft for Wales. Further updates are expected in Q4 25/26.**
10. Document sensitivity / confidentiality tagging project (linked to SharePoint migration project)	Leanne Smith / Aled Williams	Q4 26/27	Large scale project across digital
11. AI Lead to be identified and agreed	Leanne Smith	Q3 25/26	AISG to have oversight
12. Monitor usage	Kara Walsh	Ongoing from Q3 25/26	AISG to have oversight **Dec-25: AISG now regularly monitor the use cases, tooling and uptake of AI tools. This will form part of regular reporting through to IGSG in future months.**

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	Date of Review:	15/10/2025	TREND	15 (3x5)
		Date of Next Review:	15/11/2025	➡	

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of a significant deterioration in staff health and wellbeing within WAST	increased sickness levels, staff burnout, poor staff and patient experience and patient harm

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

IMTP Deliverable Numbers: 13, 14, 21, 26

Strategic Objective:

EXECUTIVE OWNER	Director of People	ASSURANCE COMMITTEE	People & Culture Committee

Risk Commentary

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.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
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.
	External - Independent Assurance - Audit Wales – Taking Care of the Carers report in October 2021 – all actions complete

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	Date of Review:	15/10/2025	TREND	15 (3x5)
		Date of Next Review:	15/11/2025		

GAPS IN CONTROLS	GAPS IN ASSURANCE
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.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
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.

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:	28/10/2025	TREND	15 (3x5)
		Date of Next Review:	28/11/2025	➡	

IF a major incident or mass casualty incident is declared	THEN there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	RESULTING IN catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

IMTP Deliverable Numbers: 1, 5, 6, 7,14, 15, 24

Strategic Objective:

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary Q1 2024/2025

The challenges across the unscheduled care system**.** Handover lost hours in **October** were **12,497** and **November** were **14,513.** 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.

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:

· 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.

· 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:

·50% of vehicles released within 10 minutes

· 75% of vehicles released within 20 minutes

· 100% of vehicles released within 30 minutes

· 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.

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 11th February in the first instance and this will be updated following conversations.

March 25 – following review at SLT, it has been agreed to maintain the score as it stands currently.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Immediate release protocol	1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed 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:	28/10/2025	TREND	15 (3x5)
		Date of Next Review:	28/11/2025	➡	

	External Independent Assurance 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.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
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 11th 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 Morriston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review of Manchester Arena Inquiry	Assistant Director of Operations	**CLOSED**	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:	28/10/2025	TREND	15 (3x5)
		Date of Next Review:	28/11/2025	➡	

			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. 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. 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.
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	**CLOSED**	Immediate Release Protocol Developed and Released August 2024. Correspondence with Welsh Government remains ongoing. 22/02/2024 - Risk 594 has also been referenced in the context of MAI presentation to Welsh Government (6th 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. 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.
3. Request from COO network to share Action cards related to risk	Executive Director of Operations	**Q1 CLOSED**	May24 – LB will follow up with COO network on the sharing of their action cards to WAST. March 24 – This risk was discussed at both JCC management and in the COO meeting. 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.
4. Ongoing monitoring of the 45MR continues, as reducing handover delays is expected to decrease the number of ambulances waiting outside hospitals, particularly within BCU.	**Assistant Director of Operations**		

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	05/12/2025	TREND	10 (2x5)
		Date of Next Review:	25/01/2026	➡	

IF	THEN	RESULTING IN
IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	THEN the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	RESULTING IN unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	2	5	10
Target	2	5	10

IMTP Deliverable Numbers: 1, 13, 14, 18, 19

Strategic Objective:

EXECUTIVE OWNER	Director of Digital Services	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary

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 help reduce / mitigate against the consequences (e.g. penalty).

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 & Awareness category (for which minimum expectations were not met.) Last measured on the **02/12**/25, WAST had achieved 9**1.21**% 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**.** This is in addition to now meeting a new category of compliance covering video surveillance.

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.

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. **In addition,** there has been an increase in inappropriate use of social media and non-corporate communication channels (e.g. Whatsapp**) resulting in reportable breaches to the Information Commissioner's Office.**

A new IG Priority Framework has been developed as a risk mitigation action. The framework applies a clear, risk-based prioritisation of tasks, ensuring that high-risk areas receive immediate attention and resources as a risk-based approach to compliance. This has resulted in further and more detailed risks being identified and raised (e.g. data sharing gaps, inappropriate social media use etc). Improvements in recent months include the maintaining of compliance levels above target for mandatory IG training, investment in the IG team and improved resilience of the specialist profession, increased visibility and reporting to IGSG, and a plan to address the final three areas of proactive auditing, data sharing gaps, and more in-depth breach investigations. Given these significant improvements, and active progress with the remaining gaps in controls, the likelihood score of this risk has been reduced to 2, reaching target score. Noting however IG and data protection risk can fluctuate quickly, this risk will continue to be managed locally and monitored regularly via IGSG.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
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. **Additional DPCM role now being recruited (Dec 26) plus a new job description being designed to provide more resilience and career pathways through the Information Governance team to support with succession planning and long-term capacity.**

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	05/12/2025	TREND	10 (2x5)
		Date of Next Review:	25/01/2026		

2. Expertise: Permanent Data Protection Officer	3. 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)	4. 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.
4. Documentation: Contracts and agreements: Data processing, Data Sharing and Employment & Consultancy	5. 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)	6. **New Information Asset Management Group has been established with TOR developed.**
6. Awareness: Staff training on updated training module (Apr 2023)	7. Training compliance monitored monthly via IGSG (captured on ESR and LMS365)
7. Monitoring: Incident Reporting and management (DATIX)	8. 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.	9. **New performance reporting now being collected to increase visibility.**
9. Awareness: Digital Notices / comms Ongoing (see Siren & recent Lock-screen notices)	10. 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. **Inappropriate use of social media Digital Notice issued 10/25.**
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. Delivery of training and awareness on 'Information Governance & Transformation: What You Need to Know' to the Transformation Support Office.
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.
GAPS IN CONTROLS	GAPS IN ASSURANCE
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. Additional investment sought for IG team to bolster capacity and ensure career progression through the specialist team (tbc in October 25). **Now captured under controls (1).**
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. 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. **Now captured under controls (2).**
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. 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. **Gaps in data sharing governance (lack of agreements for all outgoing flows).** Capacity constraints continue to impact ability to undertake audits of systems and access, timely completion of DPIAs, data breach **investigations and** management, and data flow mapping (Records of Processing Activity documentation.)
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	4. Ownership: Data Protection and Compliance Risks not fully realised.

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	05/12/2025	TREND	10 (2x5)
		Date of Next Review:	25/01/2026		

to the asset register or the dataflow is not mapped and creates a weakness in assurance (See 3)	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. (**Information Asset Management Group has now been established. Captured under controls 5.)**
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.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Ensure compliance with the appropriate IG level training across all Directorate and Departments a. Demonstrate a regular series of comms on IG and DP - complete b. Regular monitoring of training compliance through IGSG – evidence of ongoing 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. d. BAU on Siren training notices and specific guidance or advice – evidence of ongoing 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	Leanne Smith	~~Q4 2024/25~~ ~~Q2 2025/26~~ **Ongoing monitoring of Trust-wide compliance (will need to be demonstrated by March 2026) and current escalations for non-compliant individuals.** **Q3 2025/26**	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&D team. 3d. Procedures, such as audit of Welsh Clinical Portal usage, has been updated. 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 & 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. Jun 2024 - Paper to ADLT seeking support for increased awareness & training compliance 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. Latest actions: July 2025 - Letters have been issued to individuals and training is requested to be completed by end of August 2025. 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. 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. **December 2025 - Escalations for overdue, non-compliant training are ongoing, and formal actions are now being considered as the next steps. A DPIA backlog remains with 42 DPIAs due for review and an additional 35 in progress (Nov 25) meaning potential privacy issues remain unidentified and unmanaged. Without DPIAs, high risk projects may proceed without adequate safeguards, increasing the possibility of data breaches and misuse. A DPIA Backlog Recovery Plan is in development as a result.** **The IG Priority Framework designates data breaches as the highest priority. A rapid triage process has been implemented to ensure all breach**

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	05/12/2025	TREND	10 (2x5)
		Date of Next Review:	25/01/2026		

			notifications receive an appropriate and timely response. Additionally, DPCMs will attend specialised Data Breach Management training (Dec 25) to strengthen capability and compliance. **Following the recruitment of additional roles, increased capacity will enable us to address the remaining outstanding areas, including:** **Proactive audits on WAST systems to strengthen assurance.** **Closing data sharing gaps by implementing agreements and improving visibility of outgoing data flows.** **Enhancing data breach investigations and management to ensure timely and robust responses.**
2. Report on physical security to IGSG – working with fleet and estates team	Leanne Smith and Aled Williams	Q2 2024/25 Q1 2025/26 **Complete**	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 & Estates. The draft risk was approved by IGSG in July 2025 and will now progress through risk management cycles.
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 **2025/26** IG Toolkit submission	Leanne Smith	Nov24 for IG Toolkit Improvement Action Plan (with evidence to CAG) - **complete** March 2025 for 24/25 submission **complete** March 2026 for 25/26 submission **– ahead of plan**	Paper to ADLT Jun24 seeking support for completion of the IG Toolkit improvement action plan. To ensure no impact to CAG approvals for WAST research, this improvement action plan must now be met and evidenced by Nov24. 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. 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 & Awareness, where standards were not met due to the IG Training compliance being below the 85% target. Progress on the 2025/26 improvement plan, to support the IG Toolkit submission in March 2026 is approximately **90%** complete. **However, the remaining 10% relates to Video Surveillance compliance and actions are needing to be addressed.**

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:	05/12/2025	TREND	12 (3x4)
		Date of Next Review:	05/03/2025		

IF WAST fails to persuade JCC/Health Boards about WAST ambitions	**THEN** there is a risk of a delay or failure to receive funding and support	**RESULTING IN** a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	2	4	8

IMTP Deliverable Numbers: 7, 9, 11, 12, 14, 15, 20, 24, 25, 32

Strategic Objective:

EXECUTIVE OWNER	Executive Director of Strategy, Planning & Performance	**ASSURANCE COMMITTEE**	Finance and Performance Committee

Risk Commentary

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.

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 it 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 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 & treat capability. The EA skills mix (no funding from JCC) and Manchester Area Inquiry (MIA) submission are also important considerations.

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.

CONTROLS	**ASSURANCES**
	Internal & External Management (1st Line of Assurance)
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	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
5. Joint WAST Executive/JCC SLT Monthly Meeting	5. **02/12/25 This meeting has now restarted with the first one held on 26 Nov-25.**
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 **JCC Committee, Ambulance & 111 Commissioning Management Group and NEPTS DAG**	2. Minutes of meetings and a standard agenda item
	External Management (1st Line of Assurance) 1. Plans go to every bi-monthly meeting

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:	05/12/2025	TREND	12 (3x4)
		Date of Next Review:	05/03/2025	➡	

	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. **02/12/25 It is anticipated that the new Joint WAST/JCC SLT Monthly Executive Meeting will provide dedicated time for discussion on the three pathways and will likely be supported by a quality, performance & information pack from WAST.**
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 **(now the JCC 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. **02/12/25 14,512 hours were lost to hospital handover in Nov-25. Previous year's performance would suggest this will increase further in Dec-25. Whilst there has been a material reduction in handover lost hours, they are some distance from the 6,000 hours on which the roster keys are predicated.**
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. **02/12/25 2026/27 is expected to be flat cash, with a significant savings target for the Trust. The Trust is also expecting the JCC to carry out an review of WAST during the remainder of Q3 and into Q4.**

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. **02/12/2025 The Trust has responded to the draft review by the JCC, the draft 2026/27 commissioning intentions and has submitted a presentation on its outline 2026-29 IMTP identifying risks, cost pressures, emerging deliverables etc. Whilst the Trust is actively influencing the commissioning process, this is within the construct of flat cash for 2026/27.**
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.

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:	05/12/2025	TREND	12 (3x4)
		Date of Next Review:	05/03/2025	➡	

			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. **02/12/25 As above, hospital handover lost hours have seen a material reduction, however, 14,512 hours were lost to hospital handover in Nov-25. Previous year's performance would suggest this will increase further in Dec-25. Whilst there has been a material reduction in handover lost hours, they are some distance from the 6,000 hours on which the roster keys are predicated.**
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 Timeframe tbc, subject to current discussion with JCC.	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. 21/01/25 Consideration of Future Vision for NEPTS at JCC meeting on 21/02/25. 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. 18/08/25 The Director of Commissioning for Ambulance & 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. **02/12/25 The Trust is currently undertaking modelling on different options for increasing NEPTS capacity within the current resource envelope.**
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.	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. 16/04/24 The new commissioning arrangements are in transition and still quite fluid at the moment. 26/06/24 Request to commissioners to re-establish this meeting. 06/08/24 Meeting now re-established. 21/01/25 Meeting continues to operate. 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 & Ambulance Commissioning discussion with JCC colleagues. 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. **02/12/25 The first Joint WAST Executive/JCC SLT Monthly Meeting was held on 26 Nov-25**
5. Develop and roll out the Stakeholder Influencing Plan	Director of Partnerships & Engagement AD Planning & Transformation	**Q2 24/25 onwards**	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. 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. 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.

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	15/10/2025	TREND	12 (4x3)
		Date of Next Review:	15/01/2025	➡	

IF 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	**THEN** there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	**RESULTING IN** a negative impact on colleague experience and/or services to patients

	Likelihood	Consequence	Score
Inherent	5	3	15
Current	4	3	12
Target	4	3	12

IMTP Deliverable Numbers: 1, 13, 14, 19, 22, 30, 32

Strategic Objective:

EXECUTIVE OWNER	Director of People	ASSURANCE COMMITTEE	People & Culture Committee

Risk Commentary

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.

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.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
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 (4x3)
		Date of Next Review:	15/01/2025	➡	

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 DoPon 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	
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. **In maintenance and further improvement mode**	None identified
2.	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
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 **Task and Finish group to develop a partnership development day for first line managers has been re-established and work is underway.**
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. **Online learning on 365 published and advertised via Siren**
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** **(completed)**	Delay due to extended discussions with TUPs and second report for ELT in August 25 Second report provided in August. **Third report provided in September including a QIA and EIA completed and shared back to ELT with a risk register and communications strategy.**

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	19/11/2025	TREND	8 (2x4)
		Date of Next Review:	19/02/2026	➡	

IF the Trust does:	THEN there is a risk that	RESULTING IN
• not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding	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

	Likelihood	Consequence	Score
Inherent	3	4	12
Current	2	4	8
Target	2	4	8

IMTP Deliverable Numbers: 9, 12, 15, 18, 24, 25, 30, 31, 32

Strategic Objective:

EXECUTIVE OWNER	Executive Director of Finance and Corporate Resources	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary: To end of **November** 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 7 of the 2025/26 Financial Year. The score is consistent with that of Qtr. **2** 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.**135**m) 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.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
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 has occured
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**. EFG meetings held in July and August 25**
5. Welsh government reporting	5. **MMR submitted monthly to WG and monthly catch ups with F&P Delivery unit**
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 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 ELT, FPC prior to Trust Board for approval as appropriate according to value.
	External Assurances Management (1st Line of Assurance)
	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
	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	19/11/2025	TREND	8 (2x4)
		Date of Next Review:	19/02/2026		

1-10 External audit reviews

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Lack of formalised service contracts between Commissioner and WAST as a commissioned body	1. None identified.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
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

Strategic Objective 1: Providing the right care or advice, in the right place, every time		***BAF risks***
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
Strategic Objective 2: Enabling our people to be the best they can be		
13.	Culture: • Enhance and strengthen internal capacity for delivering culture change • Develop amplify employee voice to increase employee engagement • Continue the implementation of our compassionate practices approach	160, 558, 623, 201, 163
14.	Capacity: • Implement our Strategic Workforce Plan • Continue to embed a culture of positive attendance management • Continue our focus on 'getting the basics right.'	100, 160, 163, 223, 224, 558, 594, 623
15.	Capability: • Grow and develop our leadership and management capability • Reinforce and promote career pathways and professional development. • Create an environment centred around effective, ongoing conversations ('Check Ins')	100, 139, 160, 223, 224, 260, 594
16.	Strengthen Welsh Language compliance through strong leadership, enabling Welsh language to flourish	201
Strategic Objective 3: Being at the forefront of innovation and technology		
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 • Everyday essentials • Security, Safety & Cyber • Digital Pioneers • Transformation • Data, Information & Insight	163, 260, 623
Strategic Objective 4: Developing services in collaboration		
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
Strategic Objective 5: Being quality driven and clinically led		
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
Strategic Objective 6: Delivering exceptional value		
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

WAST AUDIT TRACKER 3.0 - 2025/26 Q3 INTERNAL AUDIT UPDATES (ALL) - MAR26 ARAC (PRIVATE MEETING)

ID	Audit Tracker 2.0 Action Ref.	Year / Audit Plan	Audit Type	Committee Assigned	Public or Private Committee	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No. in Audit Report	Recommendation	Action No. in Mngt Response	Management Response	Expected Evidence of Implementation	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st Revised Date	2nd Revised Date	3rd Revised Date	Action Status	*ACTION UPDATE	*DATE REVIEWED	*REVIEWED BY	*REVIEW OUTCOME	*LIST OF EVIDENCE SUPPLIED TO SUPPORT PROPOSED CLOSURE
16	656a	22/23	Internal Audit	FPC	Public	Records Management	Reasonable	Judith Birkett (Welsh Ar	Jonny Sammut	High	3.1	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	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.		30/09/2024	Not Met	31/03/2025	30/09/2025		Closed in Quarter	**25/26 Q3 Update:** **011225** (LT): Email from LS - Data processing agreement issued under the Wales Accord on the Sharing of Personal Information (WASPI) to formalise governance with Denbigh County Council (DCC). Agreement relates specifically to secure storage of paper records in line with our retention schedule. The processing activities of DCC are described, and include organisation, storage, retrieval, access, and secure disposal. Awaiting a final signature from DCC Data Protection Officer, but there is no further action from WAST at this stage. Records Services Team also have plans to review all paper records stored across WAST estate and by DCC, coupled with a forecast of ongoing storage needs based on retention schedules, and will propose a records management plan to IGSG in coming months.	01/12/2025	Leanne Smith	Completed	Emailed extract from Teams chat between LS/LT containing Q3 update. Copy of agreement developed (signed by DCC) to follow
20	635	23/24	Internal Audit	FPC	Public	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh (Welsh Ar	Rachel Marsh	Not Set	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.		30/04/2024	Not Met	30/06/2025	31/12/2025		Closed in Quarter	**25/26 Q3 - Update:** **041225**: (LT) HB advised that TM/RM had agreed that this document would not be produced. TM confirmed Sept25 ARAC meeting agreed that this audit action could be closed.	04/12/2025	Hugh Bennett	Recommendation no longer relevant	n/a
21	668	23/24	Internal Audit	QuEST	Public	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Claire 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.		30/11/2024	Not Met	31/12/2025			Closed in Quarter	**25/26 Q3 - Update:** **060126** (AK): **Proposed for closure.** This recommendation is being mitigated as the draft statutory national guidance states that every organisation must have a Listening to People Policy. This aligns with our already agreed internal proposal that the current Putting Things Right Policies will be superseded by a Listening to People Policy	06/01/2026	Claire Appleton & Alison Kelly	Recommendation no longer relevant	n/a
22	681	23/24	Internal Audit	QuEST	Public	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).		30/06/2024	Not Met	30/09/2024	31/03/2025	30/04/2026	Open				Not Set	
23	683	23/24	Internal Audit	QuEST	Public	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.		30/06/2024	Not Met	30/09/2024	31/12/2024	30/04/2026	Open				Not Set	
24	684	23/24	Internal Audit	QuEST	Public	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."		30/09/2024	Not Met	31/12/2024	31/03/2025	30/04/2026	Open				Not Set	
25	686	23/24	Internal Audit	QuEST	Public	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. "		30/09/2024	Not Met	31/03/2025	30/09/2025	30/04/2026	Open				Not Set	
26	691	23/24	Internal Audit	FPC	Public	ICT Contract Management	Reasonable	Robert Walker (Welsh A	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.		31/03/2025	Not Met	30/09/2025	30/09/2026		Open	**25/26 Q3 Update:** **111125**: (LT) Email from AW - Will accept the 2nd revised date (Mar26) applied although this will still be challenging given volume of work in concluding ongoing contract renewals and finalisation. Potential additional resources being considered to accelerate adoption to meet recommendation. **2nd Revised Date amended from Mar26 to Sep26.** **25/26 Q2 Update:**	11/11/2025	Aled Williams	Date Missed - Revised Date Required	
32	013-24/25	24/25	Internal Audit	FPC	Public	Overtime Controls	Reasonable	Liz Wedley (Welsh Ambu	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.		31/03/2026	Not Yet Due				Open					IGSG AAAs x 3 to LT 02/10/25
33	015-24/25	24/25	Internal Audit	PCC	Public	Resourcing Policy	Limited	Siobhain Frain (Welsh A	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.		31/03/2025	Not Met	30/09/2025	30/09/2026		Open				Not Set	
34	016-24/25	24/25	Internal Audit	PCC	Public	Resourcing Policy	Limited	Jonathan Edwards (Wel	Lee Brooks	High	1.3	The Resourcing Policy should be reviewed and revised (or re-drafted), 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.		31/10/2025	Not Met	30/09/2026			Open				Not Set	
35	019-24/25	24/25	Internal Audit	PCC	Public	Resourcing Policy	Limited	Jonathan Edwards (Wel	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.		30/10/2025	Not Met	30/09/2026			Open				Not Set	
36	022-24/25	24/25	Internal Audit	PCC	Public	Resourcing Policy	Limited	Siobhain Frain (Welsh A	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. This is complete. 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."		31/10/2025	Not Met	30/09/2026			Open				Not Set	
37	040-24/25	24/25	Internal Audit	PCC	Public	Exposure to Fumes	Reasonable	Nicola White (Welsh An	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.	3.1	Where possible, any relevant data source will be automated for transfer into the Data Vault.		31/03/2025	Not Met	31/05/2025	31/12/2025	31/05/2026	Open	**25/26 Q3 Update** **060126** (AK): **Propose a 3rd revised date of May26 (exception as dependent upon Digital work plan and capacity).** Further to discussions with Digital Directorate colleagues it has been agreed that automation of data transfer into the data vault will occur from May 2026.	06/01/2026	Penny Durrant/Alison Kelly	Date Missed - Revised Date Required	
38	044-24/25	24/25	Internal Audit	QuEST	Public	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.	3.1	PECI team to devise a proforma for directorates and quality improvement programmes/projects to request support and involvement to their scheme of work.	Copy of proforma developed for directorates and quality improvement programmes/projects to request support and involvement - Examples of completed proformas to demonstrate it is being utilised	30/04/2025	Not Set				Closed in Quarter	**25/26 Q3 Update** **060126** (AK): Under the new PECI structure, and in line with the Board approved Partnerships and Engagement approach, activity will now be commissioned through a defined organisation process and aligned to a small number of core IMTP priorities. This replaces the previous model where PECI independently created proforma and responses to ad-hoc directorate requests. Templates and processes will be agreed that maintain IMTP consistency and strategic alignment. When the original management response was drafted, the service change proposals were still in negotiation. The updated model means PECI will now form part of the core team leading on the Trust Quality Management System and delivery will involve PECI and other teams depending on the issue and geography. **Action No Longer Relevant**	06/01/2026	Alison Kelly, Leanne Hawker & Penny Durrant	Recommendation no longer relevant	Email from AK dated 18/12/2025 containing explanations for Audit Actions on lines 38 and 39
39	045-24/25	24/25	Internal Audit	QuEST	Public	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.	3.1	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.	Copy of documentation evidencing adoption of a population health-based approach - Sample of enhanced reporting identifying variations - Evidence of engagement with Clinical Team re: variations - Evidence of engagement with Quality Team re: variations - Sample of PECI Team advice re: how it can support	31/08/2025	Not Set				Closed in Quarter	**25/26 Q3 Update** **060126:** (AK) The expectation that PECI would lead population-health engagement is no longer feasible or aligned with Board-endorsed shift towards targeted, system-wide engagement on IMTP priorities. The OCP introduces a role that will influence and support this agenda alongside the Quality Improvement and Clinical Directorates, but PECI will not have a dedicated resource to deliver a standalone programme. Instead, population-health analytics and principles will be embedded into the foundations of all our work, supported through QIAs, EqIAs and IMTP commissioning processes, rather than delivered as isolated, targeted projects. While there may be opportunities to expand the scope of population-health activity in the future, the immediate priority is to shift toward an organisation-wide approach where population-health thinking is consistently applied across directorates, rather than led solely by PECI. **Action No Longer Relevant.**	06/01/2026	Alison Kelly, Leanne Hawker & Penny Durrant	Recommendation no longer relevant	Email from AK dated 18/12/2025 containing explanations for Audit Actions on lines 38 and 39
40	048-24/25	24/25	Internal Audit	QuEST	Public	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	Liaising with Fleet to explore use of QR Codes on vehicles to enable patients/families to access feedback surveys whilst waiting.	Copy of correspondence to/from Fleet to evidence liaison re: exploring use of QR codes for surveys in vehicles - Photos of QR codes for surveys displayed in vehicles"	31/03/2025	Not Met	31/07/2025	31/03/2026		Open				Not Set	
41	053-24/25	24/25	Internal Audit	FPC	Public	Vehicle Accident Management	Limited	Andrew Morgan (Welsh	Chris Turley	Medium	1	"Vehicle Accident Investigation Guidance 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.	Triple A documentation from the meetings, including Action Logs and copies of the proposed checklist will form part of the evidence for this action, including guidance material/checklist for managers.	30/09/2025	Not Set	31/12/2025	31/07/2026		Open	**25/26 Q3 Update** **060126** (TMN): **Requesting extension to July 2026** - The Checklist has gone through SOT with some changes to be incorporated, following this the T&F group have requested testing of the checklist in a local area prior to Pan Wales rollout. This extention will allow time for testing and then Pan Wales rollout following feedback	06/01/2026	Toni-Marie Norman / Ops SLT	Date Missed - Revised Date Required	
42	054-24/25	24/25	Internal Audit	FPC	Public	Vehicle Accident Management	Limited	Andrew Morgan (Welsh	Chris Turley	Medium	2	"Driver Training Post Investigation 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.	Triple A documentation from the meetings, including Action Logs and copies of the proposed process/documentation will form part of the evidence for this action including a central register with an established mechanism for monitoring and assurance.	30/09/2025	Not Set	31/12/2025	30/04/2026		Open	**25/26 Q3 Update** **060126** (TMN): Requesting extension to collate the required evidence as per feedback from LT. **Proposed April 2026.**			Date Missed - Revised Date Required	
43	057-24/25	24/25	Internal Audit	FPC	Public	Vehicle Accident Management	Limited	Andrew Morgan (Welsh	Chris Turley	Medium	5	"Evidence of Third-Party Damage 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.	Triple A documentation from the meetings, including Action Logs and copies of the proposed strategy will form part of the evidence for this action, including the comms strategy and a copy of the training materials/guidance to staff.	30/09/2025	Not Met	31/03/2026			Open				Not Set	
44	059-24/25	24/25	Internal Audit	QuEST	Public	Roll-out of Penthrox	Reasonable	Judith Bryce	Andy Swinburn	Medium	1	"CFR Access to Replenish Penthrox Supply Not all CFRs have access to either the Omnicell cabinets or the Penthrox 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 Penthrox safe to gain access and replenish supply. Further, the Penthrox 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 Penthrox safes. This will allow the Medicines Management team to check them against DOMs that already have the Penthrox access permission on their Abloy keys."	Omnicell system report for CFRs with registration and fingerprint enrolment numbers. Abloy key access registration report for North Wales Penthrox safes.	31/05/2025	Not Met	31/10/2025	31/12/2025		Closed in Quarter	**25/26 Q3 Update** **221225**: (JL) All active CFRs now successfully added to the Omnicell system. NW DOMs also added to access list for Penthrox safes. Penthrox supply is a continuing for volunteers but internal efforts will continue to explore solutions to make the process easier for volunteers in the long run. **Propose for closure.**	18/12/2025	Judith Bryce	Completed	Correspondence email between Huw Jackson, Gareth Parry, and Judith Bryce regarding update to Omnicell for volunteers and list of NW DOMS.
45	064-24/25	24/25	Internal Audit	PCC	Public	Occupational Health & Wellbeing	Reasonable	Kim Crichton (Welsh An	Carl Kneeshaw	Medium	2	"Enhance Occupational Health Performance Data 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."	2	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.	Enhanced performance reports, and evidence of actions taken or discussed based on the findings. Review quarterly to ensure that insights gained are translated into tangible improvements and meaningful change. First enhanced report to be available by May 2025, and to be reported within People and Culture Directorate Business Meeting on 22/05/25.	31/05/2025	Not Met	30/09/2025	30/09/2026		Open	**25/26 Q3 Update:** **181255**: (KC) On track for revised deadline. Ongoing discussions to address the missing DNA. Workaround currently being implemented, training for team to follow.	18/12/2025	Kim Crichton / Catherine Goodwin / Sarah Parry / Carl Kneeshaw	Not Yet Due - On Track (No Update Required)	

46	065-24/25	24/25	Internal Audit	PCC	Public	Occupational Health & Wellbeing	Reasonable	Kim Crichton (Welsh Am	Carl Kneeshaw	Medium	3	Trend Analysis to Focus Service Provision and Resources 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.	3	"Occupational Health will develop and implement additional internal reporting process within the Occupational Health system OPAS GQ 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. 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."	The initial action involves setting up live dashboards and configuring reports within the Occupational Health system, OPAS GQ, to track key data points such as referral reasons, health conditions and patterns related to service areas or staff groups. Once these dashboards and reports are established, monthly meetings will be scheduled with the Head of People Services / leads within People and Culture as required, starting in April/May 2025, to review both trends and discuss necessary interventions. A formal quarterly review will follow to assess the effectiveness of the dashboards, reports and interventions, with adjustments made as needed.	31/07/2025	Not Met	30/09/2026		Open	25/26 Q3 Update: 281225: (KC) - On track for revised deadline.	19/12/2025	Kim Crichton / Catherine Goodwin / Sarah Parry / Carl Kneeshaw		Not Yet Due - On Track (No Update Required)	
47	072-24/25	24/25	Internal Audit	PCC	Public	Speaking Up Safely	Reasonable		Angela Lewis	Medium	2	"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. Risk & Impact: Reduced opportunities to learn from lessons. "	2.2	"Progress continues to be made, and surveys have been routinely sent automatically from WIC since its introduction on closure of a conversation. 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. Agreed Action: Develop risk assessment framework to mitigate potential detriment (sharing of lessons learned process)	- Routine recording that questionnaires have been sent. - Meetings scheduled and lessons learned collated and shared in an appropriate forum. - Risk Assessment framework.	31/03/2026	Not Yet Due			Open		17/12/2025	Lizzie O'Shea, Catherine Goodwin, Sarah Parry		Not Yet Due - On Track (No Update Required)	
49	076-24/25	24/25	Internal Audit	PCC	Public	Speaking Up Safely	Reasonable		Angela Lewis	Medium	4	"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. The same is applicable to the records that are maintained by the Guardian for those cases received directly. 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). Further, whist 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. There is a lack of reporting and analysis of the above, including compliance with timescales, both locally and to Board-level committee. **Risk & Impact:** Limited assurances in respect of wider concerns and Speaking Up Safely cases. Timelines for dealing with cases may be protrated leading to detriment."	4	"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 (d) 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. **Agreed Action:** 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.	Reports at appropriate meetings on time with robust confidential data.	31/10/2025	Met			Closed in Quarter	25/26 Q3 Update: 171225 (LOS) Completed. **Propose to close.**	17/12/2025	Lizzie O'Shea, Catherine Goodwin, Sarah Parry	Completed		SUS Annual Report
50	075-24/25	24/25	Internal Audit	PCC	Public	Speaking Up Safely	Reasonable		Angela Lewis	High	5	"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. Risk & Impact: Speaking Up Safely cases."	5	"Safety team, safeguarding, clinical concerns, people services, the EDI team, or highly confidential Datix in our reporting. However we meet with these teams in lessons learned forums to discuss and notice themes. 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. 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. **Agreed Action:** Share themes in reporting to CEO, Board champion and Directors of Culture Change and People (in place). Share themes in lessons learned forums and in discussion of people and culture themes and trends paper (in place).	Discussion at lessons learned forums and in reporting to CEO.	31/05/2025	Not Met	31/10/2025		Closed in Quarter	25/26 Q3 Update: 171225 (LOS) - Completed. **Propose to close.**	17/12/2025	Lizzie O'Shea, Catherine Goodwin, Sarah Parry	Completed		SUS Annual Report
51	076-24/25	24/25	Internal Audit	PCC	Public	Speaking Up Safely	Reasonable		Angela Lewis	Medium	6	"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. Risk & Impact: Limited assurances in repest of Speaking Up Safely cases. "	6	"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. **Agreed Action:** Annual report to ARAC.	Report at ARAC.	30/06/2025	Not Met	30/10/2025		Closed in Quarter	25/26 Q3 Update 171225 (SP): **Propose to close.** Evidence supplied to support proposed closure.	17/12/2025		Completed		SUS Annual Report - presented to ARAC
52	077-24/25	24/25	Internal Audit	QuEST	Public	Risk Management & Board Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	1	"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. Risk & Impact: The documented guidance may become out of date as procedures change, leading to risks not being managed as intended. "	1	"Once new ways of working are finalised and introduced the risk management documentation - Risk Management Policy; Risk Management Guidelines; and the Guidance on Interpreting the Board Assurance Framework will need to be updated and reapproved.	Updated suite of Risk Management documentation.	31/03/2026	Not Yet Due			Open					Not Set	
53	080-24/25	24/25	Internal Audit	QuEST	Public	Emergency Communication Nurse System (ECNS) Implementation	Reasonable	Andrew Garner	Lee Brooks	Medium	3	"ECNS Audit Report Format Review of audit reports confirmed that they provided a mix of recognition of good practice alongside areas where corrective feedback was required. IAAD performance standards notes that when providing feedback there should be focus on the exact performance that did not meet the standard. Our review of 20 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. Currently audit reports are circulated via email to the clinician and line manager, however, there is no requirement for receipt or acknowledgement of content. Theme: Performance Monitoring Risk & Impact: Unclear and delayed feedback impact on the value and ability to influence practice of audits."	3	"Agreed Action: 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). Consideration will be given more widely on how to ensure monitoring of receipt of feedback and respective managers/local management teams updated.	Quality assurance processes will be developed and refined internally, and the IAED Accredited Centre of Excellence (for which the Trust has for ECNS) wins 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).	31/12/2025	Not Set	30/06/2026		Open	25/26 Q3 Update 250126: (LT) **1st Revised Date of June 2026 applied** 060226 (TMN): Quality Audit colleagues recruited mid December - requesting extension on this to enable time to appropriately evidence closure of this item with documentation (6 months if possible)	06/01/2026	Toni-Marie Norman / Ops SLT	Date Missed - Revised Date Required		
54	087-24/25	24/25	Internal Audit	FPC	Public	Forecasting & Modelling	Reasonable	Hugh Bennett (Welsh A	Rachel Marsh	Medium	1	"Modelling and Forecasting Process 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: - 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. - 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). - 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 metering). - 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. Theme: Information, Data Quality & Data Accuracy Risk & Impact: Ineffective arrangements resulting in wasted resources and a failure to plan effectively resulting in poorly-designed services."	1	"Agreed Action: Complete the draft Standard Operating Procedure for Forecasting & Modelling. This would include approvals, version control and evaluations. Develop a forecasting & modelling report tracker, which would enable the Forecasting & 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 & 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.	- Standard Operating Procedure and Forecasting & Modelling Report Tracker included in AAA (Alert, Advise, Assure) report to Strategy, Planning & Performance Directorate Business Leadership Team meeting. - 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.	31/03/2026	Not Yet Due			Open				Not Set		
55	088-24/25	24/25	Internal Audit	FPC	Public	Forecasting & Modelling	Reasonable	Hugh Bennett (Welsh A	Rachel Marsh	Medium	2	"Documented Procedures There is a small team responsible for carrying out forecasting and modelling activity within the Trust, consisting of a Senior Commissioning & Performance Analyst (within the Strategy, Planning & 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. An initial version of a Standard Operating Procedure (SOP) has been developed to outline the Trust's structures and processes for the management of Omda 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. 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 silos 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. Theme: Policies & Procedures Risk & Impact: Inconsistent processes leading to a lack of accountability and oversight."	2	"Agreed Action: Complete the draft Standard Operating Procedure for Forecasting & Modelling. This would include approvals, version control, access to data and evaluations. The Executive Director of Strategy, Planning & Performance and Assistant Director Commissioning & Performance are currently reviewing the capacity of the Commissioning & 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.	- Standard Operating Procedure shown in AAA report to Strategy, Planning & Performance Directorate Business Leadership Team meeting. - review of Commissioning & Performance Team's capacity / structure confirmed via Director.	30/11/2025	Not Met	31/03/2026		Open	25/26 Q3 Update 060126 (HB): AAA now being regularly reported to SP&P Business Leadership Team. SOP in drafted and will go to 29/01/26 F&M Group for approval. **Propose 1st Revised Date of Mar26** to allow time for paper/s to be presented to Committee and AAA to be submitted as evidence to support closure.	06/01/2026	HB	Date Missed - Revised Date Required		**Evidence received 060526** (via email from KS): - x5 Agendas dated: August 2025, September 2025, October 2025, 19/11/2025, and 10/12/2025 NB: Draft SOP to follow once approved by F&M Group on 29/01/26 and its been to FPC.
56	090-24/25	24/25	Internal Audit	FPC	Public	Forecasting & Modelling	Reasonable	Hugh Bennett (Welsh A	Rachel Marsh	Medium	4	"Winter Resilience Planning The following weaknesses were identified in the winter planning process: - 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. - 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. Theme: Information, Data Quality & Data Accuracy Risk & Impact: Winter resilience forecasting and modelling is ineffective with a failure to mitigate demand and capacity changes potentially impacting patient safety and staff wellbeing."	4	"Agreed Actions: 1.(As part of the Forecasting & Modelling SOP, confirm the template(s) to be used for in-house reports. 2.Build WG winter modelling scenario work into the SOP.	- Forecasting & Modelling SOP approved in SP&P BLT meeting. - Forecasting and modelling reports incorporating WG analysis and data assumptions	20/11/2025	Not Met	31/03/2026		Open	25/26 Q3 Update 060126 (HB): SOP and templates drafted (and being used). These are going to F&M Group on 29/01/26 for sign off.	06/01/2012	Hugh Bennett	Not Yet Due - Off Track (Update Required)		**Evidence received 060526** (via email from HB):- Email from HB to LB (dated 06/11/25) sharing the two main tables from winter modelling via OMDA.

57	091-24/25	24/25	Internal Audit	FPC	Public	Forecasting & Modelling	Reasonable	Hugh Bennett (Welsh A	Rachel Marsh	Medium	5	"Forecasting and Modelling Group Meeting Administration 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. 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. Ornda 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. 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). 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. Theme: Governance Risk & impact: Meetings may not be effective if they are not planned appropriately, and there may be a lack of accountability of issues escalated.	5	"Agreed Actions: 1)Introduce a AAA report for the Forecasting & Modelling Group and confirm governance route. 2)Continue to strengthen focus on work plan through the F&M Group, as it was only recently introduced before the audit.	- AAA reports (taken to SP&P BLT meeting). - Use an up to date work plan, articulated through the AAA.	30/11/2025	Not Yet Due	31/03/2026	Open	25/26 Q3 Update **060126** (HB): AAA is going to SP&P BLT, as the agreed governance route. Work Plan goes to F&M Group every month.	06/01/2026	HB	Date Missed - Revised Date Required	AAA on BLT agenda. Work Plan on F&M agenda.
58	092-24/25	24/25	Internal Audit	FPC	Public	Forecasting & Modelling	Reasonable	Hugh Bennett (Welsh A	Rachel Marsh	Medium	6	**"Oversight of Forecasting and Modelling Activity** The Forecasting and Modelling Group's (FMG) terms of reference note that the "Group will report to the Executive Director of Strategy, Planning & 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. 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. 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. As highlighted in objective 2, there was no reporting to the Trust Board or its committees on the recent winter planning exercise. **Theme**: Governance **Risk & impact**: Ineffective reporting could result in poor decision making and a lack of accountability and oversight."	6	"Agreed Actions: 1)Introduce AAA reports at FMG and SP&P BLT. 2)Winter modelling to be reported formally into Operations SLT.	- AAA reports (FMG and SP&P BLT), and - Operations SLT AAA report into ELT to show evidence of the winter modelling discussion.	31/10/2025	Met		Closed in Quarter	25/26 Q3 Update **060126 (HB):** Proposed for closure. AAA being reported to SP&P BLT as a matter of routine. Winter modelling was completed and emailed to both the Executive Directors for Ops and SP&P, but with the model changing in December, it was not reported formally to Ops SLT.	06/01/2026	Hugh Bennett	Completed	BLT Agenda with F&M AAA. Winter modelling email to Executive Directors
59	093-24/25	24/25	Internal Audit	FPC	Public	Forecasting & Modelling	Reasonable	Hugh Bennett (Welsh A	Rachel Marsh	Medium	7	"Organisational Learning 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. 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. 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. Theme: Lessons Learnt Risk & impact: Ineffective organisational learning could lead to missed opportunities for improvements and poor decision making."	7	"Agreed Action: The Forecasting & Modelling Report Tracker will record lessons learnt.	Forecasting & Modelling Report tracker; and identified as part of the AAA reporting up to SP&P BLT.	30/11/2025	Not Met	31/03/2026	Open	25/26 Q3 Update **060126 (HB):** The tracker for where the report went, how used and lessons is in draft, but is not complete at this time. **1st revised date of 31/03/2026 proposed.**	06/01/2026	HB	Date Missed - Revised Date Required	Tracker (library), but further evidence needed before closure.
60	101-24/25	24/25	Internal Audit	QuEST	Public	Start of Shift Procedure	Limited	Sonia Thompson	Lee Brooks	Medium	1	**"Awareness of SOP** In February 2025, as part of the Quality & 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. Weaknesses were noted in relation to awareness of the SOP, as well as completion of expected forms (see Key Finding 2) and the time taken to be taken to complete the checks. 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."	1	"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).	Copy of the communications.	31/10/2025	Met		Closed in Quarter	25/26 Q3 Update **060126** (TMN): Evidence Submitted to **propose closure**	06/01/2026	Toni-Marie Norman / SLT	Completed	Evidence supplied 08/01/26 (via email from TMN): 2025-053 - EMSC Bulletin - Overrun Reduction 2025-051 - EMSC Bulletin - EMS Overrun Reductions
61	102-24/25	24/25	Internal Audit	QuEST	Public	Start of Shift Procedure	Limited	Benjamin Collins	Lee Brooks	Medium	2	"Update to SOP to reflect current practices As detailed within the SOP for Start of Shift arrangements: "staff must complete their legal VOI checks (Appendix 1) to comply with the Road Traffic Act, prior to mobilising any call." As reported from a recent Quality & Support day, only 50% of those in Ambulance Care are completing the forms alongside the acknowledgements 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 VOI checks. Further, whilst the headings as per the MDVS correlate with the primary checks as included in the VOI form, the latter provides more detail/guidance for the driver completing. It is also noted that, as a result of the recent Quality & Support Day, (see objective 5) there is a need to update the SOP to align with the needs of the NSPTSA/Ambulance Care teams to "ensure that all staff regardless of their specific roles are on the same page regarding shift commencement procedures.""	2	"The Vehicle Accident Management Task & Finish Group are currently reviewing VOI 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 & Finish Group, the SOP will be updated to reflect current practice. Senior Operations Team (SOT) will maintain oversight and responsibility of this audit action.	- AAA reports from the Task & Finish Group to confirm agreed process; - copy of updated SOP to reflect practice, and - copy of AAA to approve amended SOP.	31/10/2025	Not Set	31/07/2026	Open	25/26 Q3 Update **210126** (LT): **1st revised date of July 2026 applied.** **060126** (TMN): Requesting extension to July 2026 - The report is being progressed however the T&F group have requested testing of the proposed VOI option prior to Pan Wales rollout. This extention will allow time for testing and then changes to SOP to occur			Not Set	
62	103-24/25	24/25	Internal Audit	QuEST	Public	Start of Shift Procedure	Limited	Benjamin Collins	Lee Brooks	High	3	"Lack of evidence to demonstrate compliance of checks As has been identified through the recent Ambulance Care Quality & Support day, 50% of the staff involved (circa 182) 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 & 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. 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 VOI 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. 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). "	3	"The Vehicle Accident Management T&F Group are currently reviewing VOI 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.	- AAA reports from the Task & Finish Group to confirm discussions on the VOI process and reporting mechanisms, and - an updated version of the SOP	31/10/2025	Not Set	31/07/2026	Open	25/26 Q3 Update **210126** (LT): **1st revised date of July 2026 applied.** **060126** (TMN): Requesting **extension to July 2026** - The report is being progressed however the T&F group have requested testing of the proposed VOI option prior to Pan Wales rollout. This extention will allow time for testing and then changes to SOP to occur			Not Set	
63	106-24/25	24/25	Internal Audit	QuEST	Public	Start of Shift Procedure	Limited	Sonia Thompson	Lee Brooks	Medium	4	**"Review of Consumables** 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. 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. We appreciate that consumables review will be undertaken on behalf of the paramedics at HRDs; 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."	4	"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.	- A copy of list of consumables that will be added to vehicles, _a copy of the comms to reinforce the consumable amounts - AAA report from EMG (EMS Management Group) - AAA report from Ambulance Care Service Management Meeting to confirm discussions on scheduled review consideration.	31/10/2025	Met		Closed in Quarter	25/26 Q3 Update **060126** (TMN): Evidence Submitted to **Propose Closure**	06/01/2026	Toni-Marie Norman / SLT	Completed	Evidence supplied 08/01/26 (via email from TMN): 2026-001 - EMS Bulletin - Vehicle Consumables/EMS Vehicle Consumables Bulletin/Standardised Vehicle consumable and equipment lists for vehicles NB: Actions progressed outside of the business meetings therefore no AAA reports available. However, Operations Directorate is satisfied that the actions have all been completed.
64	105-24/25	24/25	Internal Audit	QuEST	Public	Start of Shift Procedure	Limited	Benjamin Collins	Lee Brooks	High	5	"Reporting 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. Whilst the output of the Quality & Support days has been reported at Committee level, this related to an exercise completed in quarter 4 and was only in relation to Ambulance Care. The use of a central repository for completed forms (see Key Finding 3) would help facilitate reporting."	5	"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.	- AAA reports from EMG (EMS Management Group) into SOT (Senior Operations Team) to determine discussions on the SOP, and - the results of the dip sample / next steps discussions.	31/12/2025	Not Met	31/07/2026	Open	25/26 Q3 Update **060126** (TMN): Requesting **extension to July 2026** - The overruns group has been established and changes to the SOP are currently being undertaken, dip sampling will occur once changes finalised to reflect and dip sample the accurate processes.	06/01/2026	Toni-Marie Norman	Date Missed - Revised Date Required	
65	107-24/25	24/25	Internal Audit	FPC	Public	Capital Systems	Reasonable	Joanne Williams (Welsh	Chris Turley	High	2	**"Declarations of Interest / Non-Collusion** 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. 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'."	2	"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. Provide a copy of the Internal Audit report to request NWSSP Procurement confirm in writing that they will fulfill their requirements in respect of ensuring due independence / governance in all future procurement. Further to include in the Procurement Outcome Report (POR); previously the CARR, the necessary confirmation of independence by all NWSSP officers involved in the process and receipt of non-collusion forms. Expected	- Project checklist updated by Project Managers to reflect retention of Trust DOI forms. - Email to provide Internal Audit report to NWSSP Procurement with a reRequest 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.	30/11/2025	Met		Closed in Quarter	25/26 Q3 Update **070126** (LT): Email from JW received supplying evidence to support closure. **Closure Proposed** **070126** (JW): JW has confirmed action completed pending supply of evidence.	07/01/2026	James Haley & Jo Williams	Completed	**Evidence supplied 070126** (via email from JW): 3 files supplied using Monmouth as example to demonstrate all actions have been taken: Internal Audit Report Monmouth DOIs Monmouth POR signed by BP 25.09.25
66	109-24/25	24/25	Internal Audit	FPC	Public	Capital Systems	Reasonable	Joanne Williams (Welsh	Chris Turley	Medium	4	**"Annotation of contracts** 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 front 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."	4	"Cost Advisor to highlight specific detail included in the standard JCT contact. Changes to be annotated a point of signature.	Example of a signed JCT contract with changes annotated	30/06/2026	Met		Closed in Quarter	25/26 Q3 Update **070126** (LT): JW email dated 07/01/26 advising action completed, and supplying evidence. **Closure Proposed.**	07/01/2026	James Haley & Jo Williams	Completed	**Evidence supplied 070126** (via email from JW) HART JCT signed 27.12.25JCT contract details - annotation ER, TM 17.12.25
102	IA/2526-001	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Karen Jones (Welsh Amt	Carl Kneeshaw	Medium	1	**"Documented Procedures** Several templates have been developed to support the OCP process, covering areas such as the rationale for change, consultation, and feedback. However, these templates are not currently available on the Trust's SharePoint site, leading to inconsistent use and the circulation of outdated versions. Additionally, the templates could be improved to prompt for key elements such as cost implications, resource capacity, and the approval process. There are currently no formal, documented procedures available to guide managers through the OCP process. Although People Services provide support during OCP delivery, the absence of clear guidance has contributed to uncertainty among staff. Feedback from staff involved in sample testing (see Objective 2) indicated that some had no prior experience with OCPs, resulting in a lack of clarity around roles and responsibilities, particularly regarding the timing of job description reviews and the completion of Equality and Quality Impact Assessments (EQIA and QIA)."	1.1	**"Agreed Action:** There is an OCP toolkit for Managers, including template letters and standardised templates. However, these aren't stored on SIREN. The People Business Leader would share with the appropriate Manager, to ensure that letters that may change Ts & Cs are not easily accessible without People Services advice. Following feedback from this audit and to raise line manager awareness of the OCP process we will include a Manager's Easy Read Guidance document, and a Manager's checklist, added to SIREN under People Services Toolkits.	Managers Easy Read Guidance Document and a Managers Checklist of OCP toolkit available on SIREN under People Services Toolkits.	31/12/2025	Met		Closed in Quarter	25/26 Q3 Update **171225** (BF): Action Complete. **Propose to close.**	17/12/2025	Bev Flood / Liz Rogers / Sarah Parry/ Carl Kneeshaw	Completed	OCP SharePoint Page which includes: Managers Easy Read, Toolkit and Checklist

103	IA/2526-002	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Bev Flood (Welsh Ambu	Carl Kneeshaw	Medium	1	**"Documented Procedures** Several templates have been developed to support the OCP process, covering areas such as the rationale for change, consultation, and feedback. However, these templates are not currently available on the Trust's SharePoint site, leading to inconsistent use and the circulation of outdated versions. Additionally, the templates could be improved to prompt for key elements such as cost implications, resource capacity, and the approval process. There are currently no formal, documented procedures available to guide managers through the OCP process. Although People Services provide support during OCP delivery, the absence of clear guidance has contributed to uncertainty among staff. Feedback from staff involved in sample testing (see Objective 2) indicated that some had no prior experience with OCPs, resulting in a lack of clarity around roles and responsibilities, particularly regarding the timing of job description reviews and the completion of Equality and Quality Impact Assessments (EQIA and QIA)."	1.2	"Agreed Action: 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.	Flow chart available on SIREN under People Services toolkits	28/02/2026	Met	Closed in Quarter	25/26 Q3 Update 171225 (BF): Action Complete. Propose to close.	17/12/2025	Bev Flood / Liz Rogers / Sarah Parry/ Carl Kneeshaw	Completed	OCP SharePoint Page which includes: Managers Easy Read, Toolkit and Checklist
104	IA/2526-003	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Karen Jones (Welsh Amt	Carl Kneeshaw	High	2	**"Organisational Change Planning and Coordination** Historically, OCP-related activity has been treated as business-as-usual within the Trust. However, the growing volume of transformational change has exceeded existing capacity. At the time of audit, the People & Culture Directorate was managing approximately 100 active cases, including nine OCPs within a single area. Limited visibility of upcoming service-led changes continues to hinder effective resource planning. The NHS Wales Organisational Change Policy defines change as having occurred when it is "'likely to have a significant impact on the nature of the work performed or the arrangements or conditions under which the work is carried out'" (p.7). Despite this, there is currently no mechanism in place to ensure that significant organisational change is consistently planned and co-ordinated across the Trust, particularly in relation to the alignment of change community and People & Culture resources. The People and Culture Directorate Plan records some change management support for 2025/26 (e.g. Ambulance Care and APP), but no entries were available for 2024/25, limiting its use for OCP audit sampling. Audit testing highlighted the following key issues: (i) Project Classification: There is a lack of clarity on when OCPs should be treated as formal projects. This affects the ability to allocate dedicated support, assess risks and timelines at inception; and ensure consistent reporting. (ii) Experience and Support: OCP planning does not currently consider whether key individuals have prior experience with the process. A lack of previous experience impacted two of the sampled OCPs, one of which involved a manager, project manager, and trade union representative all new to the process. This contributed to gaps in understanding and inconsistent delivery."	2.1	**"Agreed Action:** 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 rescourcing issues wherever possible.	Manager's Easy Read Guidance Document and a Manager's Checklist of OCP Toolkit	31/12/2025	Met	Closed in Quarter	25/26 Q3 Update 171225 (BF): Action Complete. Propose to close.	17/12/2025	Bev Flood / Liz Rogers / Sarah Parry/ Carl Kneeshaw	Completed	OCP SharePoint Page which includes: Managers Easy Read, Toolkit and Checklist
105	IA/2526-004	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Karen Jones (Welsh Amt	Carl Kneeshaw	High	2	"Organisational Change Planning and Coordination Historically, OCP-related activity has been treated as business-as-usual within the Trust. However, the growing volume of transformational change has exceeded existing capacity. At the time of audit, the People & Culture Directorate was managing approximately 100 active cases, including nine OCPs within a single area. Limited visibility of upcoming service-led changes continues to hinder effective resource planning. The NHS Wales Organisational Change Policy defines change as having occurred when it is "'likely to have a significant impact on the nature of the work performed or the arrangements or conditions under which the work is carried out'" (p.7). Despite this, there is currently no mechanism in place to ensure that significant organisational change is consistently planned and co-ordinated across the Trust, particularly in relation to the alignment of change community and People & Culture resources. The People and Culture Directorate Plan records some change management support for 2025/26 (e.g. Ambulance Care and APP), but no entries were available for 2024/25, limiting its use for OCP audit sampling. Audit testing highlighted the following key issues: (i) Project Classification: There is a lack of clarity on when OCPs should be treated as formal projects. This affects the ability to allocate dedicated support, assess risks and timelines at inception; and ensure consistent reporting. (ii) Experience and Support: OCP planning does not currently consider whether key individuals have prior experience with the process. A lack of previous experience impacted two of the sampled OCPs, one of which involved a manager, project manager, and trade union representative all new to the process. This contributed to gaps in understanding and inconsistent delivery."	2.2	"Agreed Action:An OCP tracker will be established so multiple teams across People & Culture can review, update and have better oversight of the OCPs in existence across the organisation. This will lead to better oversight.	OCP Tracker in existence (exploration if this can be done using the same software review for case management)	31/01/2026	Not Yet Due	Open		17/12/2025	Bev Flood / Liz Rogers / Sarah Parry/ Carl Kneeshaw	Not Yet Due - On Track (No Update Required)	
106	IA/2526-005	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Karen Jones (Welsh Amt	Carl Kneeshaw	High	2	"Organisational Change Planning and Coordination Historically, OCP-related activity has been treated as business-as-usual within the Trust. However, the growing volume of transformational change has exceeded existing capacity. At the time of audit, the People & Culture Directorate was managing approximately 100 active cases, including nine OCPs within a single area. Limited visibility of upcoming service-led changes continues to hinder effective resource planning. The NHS Wales Organisational Change Policy defines change as having occurred when it is "'likely to have a significant impact on the nature of the work performed or the arrangements or conditions under which the work is carried out'" (p.7). Despite this, there is currently no mechanism in place to ensure that significant organisational change is consistently planned and co-ordinated across the Trust, particularly in relation to the alignment of change community and People & Culture resources. The People and Culture Directorate Plan records some change management support for 2025/26 (e.g. Ambulance Care and APP), but no entries were available for 2024/25, limiting its use for OCP audit sampling. Audit testing highlighted the following key issues: (i) Project Classification: There is a lack of clarity on when OCPs should be treated as formal projects. This affects the ability to allocate dedicated support, assess risks and timelines at inception; and ensure consistent reporting. (ii) Experience and Support: OCP planning does not currently consider whether key individuals have prior experience with the process. A lack of previous experience impacted two of the sampled OCPs, one of which involved a manager, project manager, and trade union representative all new to the process. This contributed to gaps in understanding and inconsistent delivery."	2.3	"Agreed Action: 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.	Review of OCP Tracker and People and Culture Directorate Plan. All projects captured on OCT Tracker.	31/01/2026	Not Yet Due	Open		17/12/2025	Bev Flood / Liz Rogers / Sarah Parry/ Carl Kneeshaw	Not Yet Due - On Track (No Update Required)	
107	IA/2526-006	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Karen Jones (Welsh Amt	Carl Kneeshaw	High	2	**"Organisational Change Planning and Coordination** Historically, OCP-related activity has been treated as business-as-usual within the Trust. However, the growing volume of transformational change has exceeded existing capacity. At the time of audit, the People & Culture Directorate was managing approximately 100 active cases, including nine OCPs within a single area. Limited visibility of upcoming service-led changes continues to hinder effective resource planning. The NHS Wales Organisational Change Policy defines change as having occurred when it is "'likely to have a significant impact on the nature of the work performed or the arrangements or conditions under which the work is carried out'" (p.7). Despite this, there is currently no mechanism in place to ensure that significant organisational change is consistently planned and co-ordinated across the Trust, particularly in relation to the alignment of change community and People & Culture resources. The People and Culture Directorate Plan records some change management support for 2025/26 (e.g. Ambulance Care and APP), but no entries were available for 2024/25, limiting its use for OCP audit sampling. Audit testing highlighted the following key issues: (i) Project Classification: There is a lack of clarity on when OCPs should be treated as formal projects. This affects the ability to allocate dedicated support, assess risks and timelines at inception; and ensure consistent reporting. (ii) Experience and Support: OCP planning does not currently consider whether key individuals have prior experience with the process. A lack of previous experience impacted two of the sampled OCPs, one of which involved a manager, project manager, and trade union representative all new to the process. This contributed to gaps in understanding and inconsistent delivery."	2.4	"Agreed Action: Experience and Support: OCP toolkit will be made available on SIREN and People Services support is always available for OCP processes.	PDF read only copies of OCP toolkit available on SIREN under People Services Toolkits.	31/12/2025	Met	Closed in Quarter	25/26 Q3 Update 171225 (BF): Action Complete.Propose to close.	17/12/2025	Bev Flood / Liz Rogers / Sarah Parry/ Carl Kneeshaw	Completed	OCP SharePoint Page which includes: Managers Easy Read, Toolkit and Checklist
108	IA/2526-007	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Liz Rogers (Welsh Amb	Carl Kneeshaw	Medium	3	"Monitoring and Reporting Organisational Change There is currently no robust mechanism in place to track OCPs across the Trust, nor are there independent checks to confirm effective application. This limits the ability to confirm whether change is being managed consistently, with appropriate oversight and opportunities for continuous improvement. While our testing of four OCPs found that trade union representatives were actively keeping their counterparts informed, there is opportunity to strengthen governance arrangements. In particular, more formalised reporting of organisational change at a trade union level would enhance transparency and support more consistent engagement."	3.1	"Agreed Action: An OCP tracker will be established so multiple teams across People & Culture can review, update and have better oversight of the OCPs in existence across the organisation.	OCP Tracker in existence	31/01/2026	Not Yet Due	Open		17/12/2025	Bev Flood / Liz Rogers / Sarah Parry/ Carl Kneeshaw	Not Yet Due - On Track (No Update Required)	
109	IA/2526-008	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Liz Rogers (Welsh Amb	Carl Kneeshaw	Medium	3	"Monitoring and Reporting Organisational Change There is currently no robust mechanism in place to track OCPs across the Trust, nor are there independent checks to confirm effective application. This limits the ability to confirm whether change is being managed consistently, with appropriate oversight and opportunities for continuous improvement. While our testing of four OCPs found that trade union representatives were actively keeping their counterparts informed, there is opportunity to strengthen governance arrangements. In particular, more formalised reporting of organisational change at a trade union level would enhance transparency and support more consistent engagement."	3.2	"Agreed Action: A quarterly review of OCPs in progress and completed will be undertaken to include lessons learned and benefits realisation.	Quarterly reviews completed	30/06/2026	Not Yet Due	Open		17/12/2025	Bev Flood / Liz Rogers / Sarah Parry/ Carl Kneeshaw	Not Yet Due - On Track (No Update Required)	
110	IA/2526-009	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Liz Rogers (Welsh Amb	Carl Kneeshaw	Medium	3	"Monitoring and Reporting Organisational Change There is currently no robust mechanism in place to track OCPs across the Trust, nor are there independent checks to confirm effective application. This limits the ability to confirm whether change is being managed consistently, with appropriate oversight and opportunities for continuous improvement. While our testing of four OCPs found that trade union representatives were actively keeping their counterparts informed, there is opportunity to strengthen governance arrangements. In particular, more formalised reporting of organisational change at a trade union level would enhance transparency and support more consistent engagement."	3.3	"Agreed Action: 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).	Minutes of CPF Meeting	28/02/2026	Not Yet Due	Open		17/12/2025	Bev Flood / Liz Rogers / Sarah Parry/ Carl Kneeshaw	Not Yet Due - On Track (No Update Required)	
111	IA/2526-010	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Liz Rogers (Welsh Amb	Carl Kneeshaw	Medium	4	"Temporary Appointments The NHS Wales Organisational Change Policy (p.27) states that "'Where an employee has been seconded or acted up in a post for a period of four continuous years or more, on the date on which they are displaced this will be considered to be their substantive post.'" However, there is no robust mechanism in place within the Trust to monitor the duration of temporary appointments. While it is expected that job role reviews during restructures will identify such cases, responsibility for monitoring rests with individual line managers. As part of our audit, we obtained a system-generated report from ESR; however, it did not clearly identify employees who had been in temporary posts for more than four years. We noted one case where an employee's temporary post began on 9 March 2020. We have since been advised that this individual was appointed on a permanent basis in December 2021, but the ESR system has not been updated to reflect this change."	4.1	"Agreed Action: 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.	Dip sampling has taken place.	31/03/2026	Not Yet Due	Open		19/12/2025	Lianne Onslow / Liz Rogers / Sarah Parry/ Carl Kneeshaw	Not Yet Due - On Track (No Update Required)	
112	IA/2526-011	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Liz Rogers (Welsh Amb	Carl Kneeshaw	Medium	4	**"Temporary Appointments** The NHS Wales Organisational Change Policy (p.27) states that "'Where an employee has been seconded or acted up in a post for a period of four continuous years or more, on the date on which they are displaced this will be considered to be their substantive post.'" However, there is no robust mechanism in place within the Trust to monitor the duration of temporary appointments. While it is expected that job role reviews during restructures will identify such cases, responsibility for monitoring rests with individual line managers. As part of our audit, we obtained a system-generated report from ESR; however, it did not clearly identify employees who had been in temporary posts for more than four years. We noted one case where an employee's temporary post began on 9 March 2020. We have since been advised that this individual was appointed on a permanent basis in December 2021, but the ESR system has not been updated to reflect this change."	4.2	**"Agreed Action:** 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.	Notice on SIREN	31/12/2025	Met	Closed in Quarter	25/26 Q3 Update 181225 (LO): Action Complete. Propose to close	18/12/2025	Lianne Onslow / Liz Rogers / Sarah Parry/ Carl Kneeshaw	Completed	2025-012 People and Culture Directorate Notice on Siren re: Updating ESR- Reminder for Managers (Dec 2025)

113	IA/2526-012	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Liz Rogers (Welsh Ambu	Carl Kneeshaw	Medium	4	"Temporary Appointments The NHS Wales Organisational Change Policy (p.27) states that ""Where an employee has been seconded or acted up in a post for a period of four continuous years or more, on the date on which they are displaced this will be considered to be their substantive post." However, there is no robust mechanism in place within the Trust to monitor the duration of temporary appointments. While it is expected that job role reviews during restructures will identify such cases, responsibility for monitoring rests with individual line managers. As part of our audit, we obtained a system-generated report from ESR; however, it did not clearly identify employees who had been in temporary posts for more than four years. We noted one case where an employee's temporary post began on 9 March 2020. We have since been advised that this individual was appointed on a permanent basis in December 2021, but the ESR system has not been updated to reflect this change."	4.3	"Agreed Action: Quarterly reporting for temporary/FTC/secondment appointments and reviewed by People Service Team and Workforce Planning Team.	Quarterly report.	30/04/2026	Not Yet Due	Open		18/12/2025	Lianne Onslow / Liz Rogers / Sarah Parry / Carl Kneeshaw	Not Yet Due - On Track (No Update Required)	
114	IA/2526-013	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Liz Rogers (Welsh Ambu	Carl Kneeshaw	Medium	5	"Organisational Learning Our review of sampled OCPs identified varying approaches to capturing lessons learned and benefits realisation: - APP: As a formal project, APP maintained a lessons learned log; however, this has not been widely shared. A populated benefits register exists, though it was considered too early to record benefits realisation. Initial post-implementation feedback was gathered, with a further session planned for September 2025. - Volunteers Services: No lessons learned, or benefits realisation have been recorded to date. A six-monthly review of the reconfigured service is, however, planned. - Bryn Tirion Relocation: The Project Initiation Document references post-project evaluation and lessons learned. While lessons were discussed at the May 2025 Project Board, they have not been formally documented. Similarly, no benefits realisation has been undertaken. - PTR: No formal documentation of lessons learned, or benefits realisation was identified. While consultation outcomes indicate that reviews of the operating model are planned at six- and twelve-months post implementation, we were advised that these discussions have occurred informally at team meetings and have not been formally recorded. Currently, there is no structured process in place to prompt or support the consistent recording and sharing of lessons learned of benefits realisation across OCPs."	5.1	"Agreed Action: Formal projects will continue to review lessons learnt and benefits realisation as part of the formal project management process. Those involved (People & Culture/Business areas/TUPs) in an OCP process will undertake reviews on a quarterly basis to review the effectiveness of the OCP processes in train and completed; and consider opportunities for continuous improvement as well as the realisation of benefits. This will be supported by a checklist.	Checklist completed 3 months post OCP	30/04/2026	Not Yet Due	Open		17/12/2025	Bev Flood / Liz Rogers / Sarah Parry / Carl Kneeshaw	Not Yet Due - On Track (No Update Required)	
115	IA/2526-014	25/26	Internal Audit	PCC	Public	Organisational Change	Reasonable	Sarah Davies (Welsh Ar	Carl Kneeshaw	Medium	5	"Organisational Learning Our review of sampled OCPs identified varying approaches to capturing lessons learned and benefits realisation: - APP: As a formal project, APP maintained a lessons learned log; however, this has not been widely shared. A populated benefits register exists, though it was considered too early to record benefits realisation. Initial post-implementation feedback was gathered, with a further session planned for September 2025. - Volunteers Services: No lessons learned, or benefits realisation have been recorded to date. A six-monthly review of the reconfigured service is, however, planned. - Bryn Tirion Relocation: The Project Initiation Document references post-project evaluation and lessons learned. While lessons were discussed at the May 2025 Project Board, they have not been formally documented. Similarly, no benefits realisation has been undertaken. - PTR: No formal documentation of lessons learned, or benefits realisation was identified. While consultation outcomes indicate that reviews of the operating model are planned at six- and twelve-months post implementation, we were advised that these discussions have occurred informally at team meetings and have not been formally recorded. Currently, there is no structured process in place to prompt or support the consistent recording and sharing of lessons learned of benefits realisation across OCPs."	5.2	"Agreed Action: Whilst our approach is primarily culture and capability focussed, rather than process driven, we recognise the importance of being able to evidence benefits and lessons learned. We will be documenting lessons learned through change initiatives and sharing these widely through a case study approach, highlighting practical examples of people focused changed and the impact on individuals, teams and outcomes. These case studies will be made available through our Change Community and other internal channels (including the CMT Change Management Workstream) helping to spread good practice, prompt reflection and inspire local adaptation. As a tangible measure of impact, we will also monitor relevant NHS Wales Staff Survey indicators to help track cultural shifts over time. This will be supplemented by qualitative feedback gathered through our engagement activities.	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	31/03/2027	Not Yet Due	Open		17/12/2025	Sarah Davies / Sarah Parry / Carl Kneeshaw	Not Yet Due - On Track (No Update Required)	
116	IA/2526-015	25/26	Internal Audit	FPC	Public	Manchester Arena Inquiry	Substantial	Judith Bryce (Welsh Aml	Lee Brooks	Medium	1	"Impact of MIST Day Non-Attendance In relation to four recommendations from the MAI (including one not selected for sample testing), the Trust has developed and adopted specific measures to enhance its ability to respond effectively to a major incident. These measures were supported by face-to-face training sessions delivered through the Trust's MIST days. However, analysis of attendance data highlights potential gaps in training coverage: (i) Ten Second Triage Tool (TST)/Major Incident Triage Tool (MITT) – These tools represent improved triage arrangements adopted by multi-agency emergency services across Wales. Training was delivered via a 17-slide presentation during the 2023/24 MIST days. However, attendance records indicate that 194 Emergency Medical Services (EMS) staff and 112 Ambulance Care Services (ACS) staff did not attend (approximately 10% of the workforce). There is no evidence to confirm whether these staff received the training through alternative means. (ii) Pax Carry Sheet –This lightweight, high-quality, and versatile rescue aid was procured for every emergency vehicle across the Trust. Training was delivered via a single slide within the broader 'Safer Handling' session during the 2024/25 MIST days. Attendance data shows that 168 EMS staff and 65 ACS staff did not attend (approximately 11% of the workforce), and again, there is no evidence of alternative training provision for these staff. Whilst we acknowledge that an acceptable MIST compliance was deemed to have been reached, to facilitate 'go live' of the equipment from 1 April 2024 (81.45% as at 12 March 2024), review of the Trust's current training arrangements did not identify any plans to provide further coverage of these specific training needs. While the financial submission to the NHS Wales Joint Commissioning Committee (JCC) highlights training gaps, these relate specifically to additional training for major incident Commanders, rather than the frontline training requirements associated with the MAI report recommendations."	1	"Agreed Action: Following the feedback received, a multi-disciplinary team has identified solutions to address the issue. It was noted that the audit numbers (194 EMS and 112 ACAs) may have decreased as employees returned from absences like long-term illness or maternity leave. The ESR team is working to identify those who still need training. The Learning & Development team will then engage with these individuals to ensure compliance with the new triage tools and PAX carry sheets. An eLearning package by L&D has been recommended as the most efficient method for delivering remedial training. This package will be hosted on the Trust's LMS365 platform and made available to all staff, supporting ongoing CPD activities and new starters. We are consulting with neighbouring ambulance services for similar training materials to expedite this process. If unavailable, the Trust can develop its own materials using existing resources. Development of a new eLearning package may take until the end of Q3, but utilising existing packages could significantly reduce this timeline. The EMS Management Group (EMG) will monitor compliance and progress. Once available, the eLearning package will be a monthly agenda item for EMG to track progress and address any issues. Progress reports will be provided through standard assurance routes. We aim for completion by the end of the 2025/26 financial year, assuming all staff can undertake training. EMG will oversee this action until all necessary staff have completed the required training with approval for sign off to be sought from SOT.	AAA repors from EMG into SOT on the monhtly reporting of compliance.	28/02/2026	Not Yet Due	Open				Not Set	
120	n/a	25/26	Internal Audit	PCC	Public	Mandatory In-Service Training	Reasonable	Jo Kelso (Welsh Ambula	Carl Kneeshaw	Medium	1	Upon update of the 'Management of Statutory and Mandatory Training and Utilisation of CPD Hours' guidance (May 2025), there was the expectation that operational managers share with staff. However, during discussions with members of staff, it was noted that they had not received any communication in relation to the document and were unaware of its existence. Further, despite the May issue date, it wasn't made available on Siren until later in the year – appearing under policies in September 2025 and in a news bulletin in October 2025.	1	•Ensure that updated policies and guidance documents are promptly and clearly communicated to all relevant staff, through established channels at the time of release. •Introduce periodic checks or feedback mechanisms to assess staff awareness of newly issued guidance, especially where compliance is impacted.	•Updated guidance shared through planned communication channels (emails, meetings, bulletins) and documented in communication plans. •Evidence that staff have received, understood and acknowledged the guidance, supported by meeting records, feedback, logs etc.	31/05/2026	Not Yet Due	Open		22/12/2025	Sarah Parry	Not Yet Due - On Track (No Update Required)	
121	n/a	25/26	Internal Audit	PCC	Public	Mandatory In-Service Training	Reasonable	Jo Kelso (Welsh Ambula	Carl Kneeshaw	Medium	2	The Trust's statutory and mandatory training aligns with the minimum standard required across all other NHS Wales bodies, with compliance recorded via ESR (and through attendance at the MIST days). However, in terms of reviewing/monitoring skill activity for patient facing members of staff, there is currently no organisational oversight to ensure all roles are appropriately aligned with the minimum competency requirements to their scope of practice. As a result, there is limited assurance that all roles are appropriately matched to the minimum competency requirements, which may impact the effectiveness of training provision and workforce capability.	2	•Develop a formal framework to review and monitor operational and clinical skill activity for patient-facing staff to ensure alignment with role-specific competency requirements. •Conduct a comprehensive mapping exercise to ensure all patient-facing roles are appropriately matched to the minimum competency standards required for safe and effective practice. •Introduce regular audits or reporting mechanisms, to an appropriate forum, to provide assurance that staff competencies are being maintained and developed in line with organisational expectations.	•Documented framework outlining how clinical and operational skills are monitored. •Completed mapping exercise showing alignment of patient-facing roles to competency standards (covering the CSTF & WG mandated topics) and records of actions taken in response to identified gaps or risks. •ESR and local reports showing compliance trends, intervention tracking and updates to competency requirements if applicable.	31/08/2026	Not Yet Due	Open		22/12/2025	Sarah Parry	Not Yet Due - On Track (No Update Required)	
122	n/a	25/26	Internal Audit	PCC	Public	Mandatory In-Service Training	Reasonable	Jo Kelso (Welsh Ambula	Carl Kneeshaw	Medium	3	Our review of MIST Day attendance monitoring arrangements identified that no formal processes are currently in place to address persistent non-compliance. This was evidenced through our sample testing, where all 30 staff members had failed to attend a MIST Day for two consecutive years or more, since the programme's inception in 2022/23. Despite this repeated non-attendance, there was limited evidence of structured follow-up or escalation, and no defined accountability framework to support or justify non-compliance. This gap in process and oversight presents a risk to maintaining minimum competency standards across operational roles. The same is applicable to ESR module completion – despite reporting provided locally in respect of non-compliance, there is minimal evidence of intervention by respective line managers to address.	3	•Develop and enforce a structured process to address persistent non-attendance at MIST days, including defined escalation steps, accountability measures and reporting to an appropriate forum. •Establish clear roles and responsibilities for monitoring and responding to training non-compliance ensuring line managers are actively engaged in follow up and resolution. •Enhance the use of ESR and local reporting tools to track compliance trends and trigger timely interventions for staff who repeatedly fail to meet training requirements.	•Documented process for managing MIST Day non-attendance, outlining escalation steps, accountability measures and reporting requirements; signed off by senior management. •Governance document detailing line managers' responsibilities for follow up and resolution •A compliance dashboard/reported generated from ESR or local system, showing trend analysis and intervention actions for repeat non-compliance.	31/12/2026	Not Yet Due	Open		22/12/2025	Sarah Parry	Not Yet Due - On Track (No Update Required)	
123	n/a	25/26	Internal Audit	PCC	Public	Mandatory In-Service Training	Reasonable	Jo Kelso (Welsh Ambula	Carl Kneeshaw	Medium	4	The Trust identified limitations in accessing ESR e-learning packages via iPads issued to a significant proportion of the operational workforce. To address this, the Learn365 app, accessible through the Microsoft Teams platform, has been adopted to improve access to e-learning. Although all relevant staff now have access to the Learn 365 platform, we note that not all e-learning modules are currently available on the platform. This is not limited to the modules from ESR – rather additional training modules, required to be completed to allow staff members to undertake their roles effectively, that are available on a further platform (On-Click). As a result, staff have been accessing three platforms to maintain full compliance. We were advised that the delay in transitioning fully to Learn365 is primarily due to resource constraints within the Learning and Development Team and the need to update training content. In addition, while compliance reports can be generated from Learn365, the lack of data integration with ESR means that updates must be manually entered into ESR three times a week – a process described as time consuming and inefficient.	4	•Provide clear guidance to staff on how to navigate the training platform. •Complete the systems migration onto one platform and ensure it is fit for purpose and easily accessible on iPads and mobile devices. •Explore options for automating data transfer between Learn365 and ESR to eliminate manual updates, reduce administrative burden and improve data accuracy. •Develop regular communications to managers and teams on the need to complete training in a timely way. •Produce reports for sharing with managers on training completions and escalate to senior managers where necessary.	•Communications issued to staff regarding platform use and compliance. •Evidence of system migration and design discussions/ accessibility requirements for mobile devices. •Technical feasibility report outlining integration options and automation proposals vs manual data entry frequency and associated resource impact. •Copies of communications sent to managers and staff reminding them of training deadlines. •As per KF3, a compliance dashboard/reported generated from ESR or local system, showing trend analysis and intervention actions for repeat non-compliance.	31/12/2026	Not Yet Due	Open		22/12/2025	Sarah Parry	Not Yet Due - On Track (No Update Required)	
125	n/a	25/26	Internal Audit	QuEST	Public	Clinical Equipment	Reasonable	Jonathan Wilson	Andy Swinburn	Medium	1	A review of the Management of Medical Devices Policy identified a reference to an equipment 'standardisation policy'; however, it was confirmed that no such policy currently exists within the Trust. It was also noted that the policy does not specify which items of clinical equipment require regular maintenance. Additionally, the Disposal Procedure (see objective 6) is overdue for review, with its last scheduled update dated September 2023.	1	Update the Management of Medical Devices Policy to ensure it reflects current practice within the Trust, including: clarifying the scope, frequency and responsible parties for equipment maintenance by means of an appendix; and amending the reference to an equipment standardisation policy to clarify the standardisation process managed by clinical equipment working group. Conduct a formal review of the Disposal Procedure and update as necessary to ensure alignment with current operational and regulatory requirements.	•Management of Medical Devices Policy: Evidence of policy review and updated document for approval by Policy Group •Disposal Procedure: Evidence of procedure review and, if applicable, updated and approved document.	31/03/2026	Not Yet Due	Open					
126	n/a	25/26	Internal Audit	QuEST	Public	Clinical Equipment	Reasonable	Jonathan Wilson	Andy Swinburn	High	2	A key finding from the Appropriately Equipped Paramedics review (WAST-1920-16: Limited Assurance) highlighted the absence of a centralised clinical equipment list. The Trust responded by exploring RFID tracking, and the 2020/21 follow up review (WAST-2021-33), noted progress toward implementing an RFID inventory system for high-value equipment. Meanwhile, electronic records were developed, including a list of high-value items stored at the Hub. The last update in August 2021 set a target date of March 2022 for RFID implementation, but the recommendation was later removed (closed) from the tracker. RFID has still not been implemented. While individual databases now exist for specific equipment types (e.g. Defibrillators, Mangar Cushion, Lucas Devices and Suction Units), a centralised inventory system remains absent. Such a system would support lifecycle tracking and inform procurement decisions for new or replacement equipment.	2	**Agreed Action 1**: •Reassess the suitability of RFID to assist in centralised asset management of clinical equipment; •Develop and maintain a Trust-wide centralised database for clinical equipment. Details to include equipment type and location, condition, maintenance schedule, expected lifecycle; and replacement planning. •Consolidate individual databases (Defibrillators, Mangar Cushion, LUCAS devices, suction units) into the centralised system.	**Expected Evidence of Implementation 1:** •Evaluation of suitability of RFID system against asset management criteria •Populated and active centralised database for all clinical equipment	31/01/2026	Not Yet Due	Open	<u>**25/25 Q3 Update**</u> **221225**: (JL) RFID configuration meeting taking place 22 Dec 2025 followed by a meeting to evaluate the system against the asset management requirements. As part of this work the individual databases of clinical equipment have been incorporated into the central system.	22/12/2025	Jonathan Wilson	Not Yet Due - On Track (No Update Required)	Meeting arrangements and centralisation of clinical equipment onto the system.[to be supplied]
127	n/a	25/26	Internal Audit	QuEST	Public	Clinical Equipment	Reasonable	Jonathan Wilson	Andy Swinburn	High	2	A key finding from the Appropriately Equipped Paramedics review (WAST-1920-16: Limited Assurance) highlighted the absence of a centralised clinical equipment list. The Trust responded by exploring RFID tracking, and the 2020/21 follow up review (WAST-2021-33), noted progress toward implementing an RFID inventory system for high-value equipment. Meanwhile, electronic records were developed, including a list of high-value items stored at the Hub. The last update in August 2021 set a target date of March 2022 for RFID implementation, but the recommendation was later removed (closed) from the tracker. RFID has still not been implemented. While individual databases now exist for specific equipment types (e.g. Defibrillators, Mangar Cushion, Lucas Devices and Suction Units), a centralised inventory system remains absent. Such a system would support lifecycle tracking and inform procurement decisions for new or replacement equipment.	2	**Agreed Action 2:** •Implement an Asset Management Software system (such as eQuip) ahead of Scan for Safety Wales.	**Expected Evidence of Implementation 2:** •Evidence of an implemented Asset Management Software System.	30/06/2026	Not Yet Due	Open					
128	n/a	25/26	Internal Audit	QuEST	Public	Clinical Equipment	Reasonable	Jonathan Wilson	Andy Swinburn	Medium	3	Servicing of clinical equipment is carried out either in-house or via external contracts, with records maintained by both the Trust and suppliers—an improvement from previous audit findings. However, gaps remain: •Defibrillators: Serviced externally, with monthly reports listing only upcoming service dates. The August 2025 report showed 59 of 550 units (11%) overdue for servicing. The report lacks service history and age profiling, limiting oversight of lifecycle status. •Mangar Lifting Cushions: Serviced in-house on a rotational schedule. Records reviewed during the audit confirmed all items were within valid service dates. An age profile database is maintained to support replacement planning. •Lucas Devices: Serviced externally, with service history and upcoming dates recorded in a Trust-accessible database. All items were within valid service periods at the time of review. The current policy does not specify which equipment requires regular maintenance (see Key Finding 1), and 10 defibrillators were listed with 'unknown' locations, indicating potential loss or tracking issues.	3	•Improve maintenance records to ensure service reports include both historical and upcoming service dates. •Investigate the defibrillators overdue for servicing and ensure prompt scheduling •Include details of equipment age and expected lifecycle within the centralised database to support replacement planning (see key finding 2). •Clarify maintenance requirements to specify which items require regular servicing and by whom (see key finding 1). •Investigate missing equipment and strengthen location tracking controls (see key finding 2).	**Expected Evidence of Implementation:** •Updated service reports showing both historical and upcoming service dates. •Confirmation that overdue units have been serviced or scheduled, with supporting records. •Database entries showing equipment age and expected lifecycle details. •Revised Medical Devices Policy specifying maintenance requirements and responsible parties. •Updated inventory records resolving 'unknown' locations and documentation of tracking enhancements.	28/02/2026	Not Yet Due	Open					

129	n/a	25/26	Internal Audit	QuEST	Public	Clinical Equipment	Reasonable	Jonathan Wilson	Andy Swinburn	Medium	4	A review of the minutes and papers for the Clinical Equipment Working Group (CEWG) identified occasional references to equipment-related incidents, typically as part of wider discussions on specific items. For example, a presentation was delivered to the group in response to an increase in Datix reports concerning failures of the Optical Astray device. However, Datix reports relating to equipment-related incidents are not routinely received or reviewed by the CEWG. This limits the group's ability to systematically monitor trends, identify recurring issues, and use incident data to inform decisionmaking around equipment management and procurement.	4	•Ensure Datix reports related to equipment incidents are routinely submitted to and reviewed by the CEWG. •Add a standing agenda item to CEWG meeting agendas for reviewing equipment related incidents. •To facilitate trend analysis and strategic planning, implement a dashboard/summary tracker of equipment-related Datix reports highlighting frequency of incidents, types of equipment involved, severity and outcomes; and actions taken.	•CEWG meeting agendas, papers and associated actions/minutes. •Tracker of equipment-related Datix reports	31/12/2025	Not Met	31/03/2026		Open	25.26 Q3 Update **2025Q3: (LT) 1st revised date of March 2026** to afford sufficient time for appropriate evidence to be collated and submitted. **2Q1225:** (JL) Individual Datix reports related to clinical equipment are now a standing agenda item at CEWG with the first review of these taking place in November 25. Future meetings will also show tracking of Datix reporting trends for clinical equipment-related incidents.	22/12/2025	Jonathan Wilson	Not Yet Due - On Track (No Update Required)	Partial evidence received 22/12/25: Agenda for CEWG
130	n/a	25/26	Internal Audit	FPC	Public	IMTP Development Process	Substantial	James Houston - (Welsh	James Houston	Medium	1	The Trust is experiencing an increasing volume of transformational change both internally and externally (such as with the NHS Wales Joint Commissioning Committee (NWJCC) and the Ambulance Performance Framework) that impacts resource capacity. As new deliverables emerge throughout the year, there is a need to strengthen how these are recorded and prioritised. The absence of a consolidated tracker means there is currently no robust mechanism to clearly determine the: • **Number of Submissions**—no document was provided during the audit that clearly records all IMTP submissions received and their prioritisation. • **IMTP Actions Carried Forward**—there is limited recording and visibility of the number of IMTP actions carried forward and how they are prioritised alongside new deliverables. For example, at the January 2025 prioritisation workshop, it was reported that 46 actions were rolling forward into 25/26 - 14 prioritised as must do's, 32 as should do's, 1 could do, 1 not categorised. Many confirming as deliverable in Q1. While fluctuations in carried forward actions are expected as the IMTP plan is being drafted, there was a lack of clarity and reconciliation with those highlighted at the workshop compared to Finance & Performance Committee (FPC) reporting (26 May 2025) of IMTP actions carried forward, e.g. 27 directorate-led actions have been carried forward to the IMTP (2025-28), but the number of CMT-specific IMTP priorities were unclear. • **Rationale** – the Integrated Strategic Planning & Development Group (ISPD) highlight report to the Strategic Transformation Board (STB) on 20 December 2024 detailed that approximately 25% of current IMTP actions were being carried forward into 2025/26, contributing to an already overburdened work plan with 152 new actions. The reason for including actions within the IMTP, particularly where priorities have shifted or are being carried forward has not always been clearly defined, e.g. continual development and implementation.	1	•Design and implement a centralised digital tracker to record and monitor all IMTP deliverables. The tracker will include a clear process for capturing prioritisation decisions, (e.g. deliverables to be carried forward/closed/amended) along with clear lines of accountability and reporting across committees and directorates. •Establish and communicate a clear and structured process for responding to organisational changes or new emerging priorities that may impact delivery of existing IMTP deliverables to support consistent decision-making and resource allocation. •All IMTP deliverables to be assigned with a robust referencing number to align the IMTP document and digital tracker.	•Centralised Digital Tracker •Change Control Process	31/12/2025	Not Met	31/03/2026		Open	25.26 Q3 Update **2Q1225 (JH):** Original implementation date not achieved as IMTP development continuing in to Q4 where centralised digital tracker and change control process will be refreshed and embedded. **Off Track - 1st revised date of 31/03/26 proposed.**	19/12/2025	James Houston, Assistant Director of Planning & Transformation	Date Missed - Revised Date Required	
131	n/a	25/26	Internal Audit	FPC	Public	IMTP Development Process	Substantial	James Houston - (Welsh	James Houston	Medium	2	Although the PPF business case process was formally approved by ISPD on 22 March 2024, it was not applied during the 2024/25 IMTP planning cycle. Funding decisions were appropriately escalated for approval, e.g. ELT, however, the Framework's use was limited due to a lack of communication, supporting templates, and a mechanism to record submissions, limiting consistency and oversight.	2	•Review and implement the business/investment case submission process as part of the wider review of the IMTP Delivery approach for 2026-29. •Update IMTP Planning Guidance for 2026-29 to reflect revised approach and build into project plan.	•IMTP Planning Guidance •IMTP Project Plan	31/12/2025	Met			Closed in Quarter	25.26 Q3 Update **2Q1225 (JH): IMTP Project Plan & investment (cost pressure) proposals** – The IMTP High level plan and IMTP planning guidance has been refreshed to outline the approach for 2026/27 cost pressure proposals. A core pillar of the technical IMTP planning approach includes the process of considering cost pressure proposals. In addition a separate more detailed guidance document has been developed outlining the approach. Work is underway to collate and consider cost pressure proposals for 26/27. The guidance has been reviewed by the Financial Sustainability Board (FSB) and Strategic Transformation Board in (Nov/Dec). A clear approach has been agreed and work is ongoing throughout January to score and prioritise proposals for executive / board review at the end of Jan. Approach has been built into the IMTP Project plan. Work to be completed in Q4. **Completed - Proposed for closure.**	19/12/2025	James Houston	Completed		High Level IMTP Planning Guidance IMTP Investment approach Guidance High level IMTP Project Plan
152	n/a	25/26	Internal Audit	FPC	Public	IMTP Development Process	Substantial	James Houston - (Welsh	James Houston	Medium	3	While a project management approach was adopted, project planning lacked clarity around key responsibilities and timescales contributing to delays in the development of the 2025-28 IMTP (see Appendix A): •IMTP Project Team: Attendance at project team meetings was generally good, but varied across directorates, with some (People & Culture and Quality, Safety and Patient Experience) showing a notable trend of lower engagement. •Project Plan: An email to the team (9 December 2024) requested initial IMTP narrative sections to be drafted by 13 December 2024. However, the Project Plan detailed some of these tasks with deadlines at the end of January 2025 impacting the first IMTP draft, which was due 31 January 2025. The Plan has not been updated to record when the IMTP narrative sections were completed. Other key milestones, such as directorate plan submissions, CMT workshops, and draft IMTP reporting dates are also not recorded. •Operational Delays: There was a delay in directorate plans being submitted and CMT workshops were scheduled late January 2025 despite the first IMTP draft being due 31 January 2025. IMTP project reporting to ELT (12 February 2025) noted that IMTP narrative requests had a 'Red' RAG status as there were few deliverables identified for years 2 and 3, and year 1 lacked SMART objectives. •Reporting Delays: Reporting to Non-Executive Directors (NEDs) was delayed. Initially scheduled for the week commencing 17 February 2025, the draft was not shared until 3 March 2025. There was no formal communication issued to notify them of the delay.	3	•Review the IMTP project delivery arrangements and membership to ensure appropriate attendance and engagement across the organisation. •Detailed IMTP project plan to be developed with key leads identified, setting out clear responsibilities and milestone dates. •Embed a regular and robust monitoring and progress reporting process as part of the IMTP development project arrangements. Risks to be reported and escalated through the IMTP governance structures including cause, impact and proposed mitigation strategies.	•IMTP Development Group (Terms of Reference) •IMTP Project Plan •IMTP AAA reporting	31/12/2025	Met			Closed in Quarter	25.26 Q3 Update **3Q1225 (JH): Completed - Proposed for Closure.** **IMTP Delivery Structure** – IMTP delivery arrangements reviewed and refreshed. A formal IMTP Development Group established with a revised Terms of Reference and cross directorate membership. High level IMTP project plan developed and actively monitored through the IMTP Development Group reporting into the Integrated Strategic Planning & Development Group. Included in evidence pack. **IMTP Project Plan** – A high level IMTP project plan has been developed and is being monitored through with IMTP Development Group. Included in evidence pack. **IMTP AAA report** – AAA highlight reports produced following each IMTP Development Group and submitted to ISPD. Included in evidence pack.	19/12/2025	James Houston	Completed		IMTP Development Group Terms of Reference High level IMTP Project Plan IMTP Development Group AAA highlight report

ID	Audit Tracker 2.0 Action Ref.	Year / Audit Plan	Audit Type	Committee Assigned	Public or Private Committee	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No. in Audit Report	Recommendation	Action No. In Mngt Response	Management Response	Expected Evidence of Implementation
27	155	23/24	External Audit	QuEST	Public	Quality Governance Follow Up Review	Not Rated	Kate Blackmore	Liam Williams	Not Set	2	"**Quality Strategy Monitoring** 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. "	2	"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 provdied 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.	
28	156	23/24	External Audit	QuEST	Public	Quality Governance Follow Up Review	Not Rated	Vince Baglole	Liam Williams	Not Set	3	"**Clinical Audit Plan** 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."	3	"We will review the communication lines between CQGG, 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."	
29	159	23/24	External Audit	QuEST	Public	Quality Governance Follow Up Review	Not Rated	Claire Appleton	Liam Williams	Not Set	3.1	"**Mortality Reviews** 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.	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"	
30	167	23/24	External Audit	QuEST	Public	Quality Governance Follow Up Review	Not Set	Hugh Bennett	Liam Williams	Not Set	8.3	"**Quality Performance Reporting and Learning** 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."	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"	
31	168	23/24	External Audit	QuEST	Public	Quality Governance Follow Up Review	Not Set	Hugh Bennett	Liam Williams	Not Set	8.4	"**Quality Performance Reporting and Learning** 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"	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"	
74	EA/2425-004	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	1	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru	01a	"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"	
75	EA/2425-005	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	1	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru	01b	"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 reopened and adjusted or additional information provided"	
76	EA/2425-006	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	1	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru	01c	"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."	
77	EA/2425-007	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	2	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	02a	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.	
78	EA/2425-008	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	2	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	02b	"Heads of Service to develop Improvement trajectories for incident closures which will be monitored through service focus area Quality Management Group"	
79	EA/2425-010	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	4	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.	04a	"SOP to be reviewed for current accuracy and then approved by Senior Quality Team"	
80	EA2425-011	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	4	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.	04b	"Commence Quarterly Complaints Audit to provide assurance that SOP is being followed."	
81	EA/2425-013	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	6	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	6b	"Senior Quality Team to undertake options appraisal of digital action planning software to enhance organisational assurance in respect of action plan completion"	
82	EA/2425-014	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	6	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	6c	"In order to set an achievable target within a continuous improvement journey, focus in the next year will be prioritised on how YCFF are being included 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."	
83	EA/2425-015	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	6	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	6c	"WAST to support workplan for OfWCMS Incident Workstream to provide enhanced definitions and guidance for YCFF and ensure ambulance leaders can utilise it more confidently"	
84	EA/2425-016	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	9	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	9	"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.	
85	EA/2425-017	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	10	WAST should ensure the description field is completed correctly on the Datix Cymru system and that these are subject to validation checks.	10	"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.	
86	EA/2425-018	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	1	WAST to ensure that inclusion of additional contacts, where appropriate, is undertaken in relevant complaint records. An audit process may provide assurance of this.	1	"Training on why and how to attach additional contacts was provided by Central OfWCMS 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.	
87	EA/2425-019	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	2	WAST to undertake further training in relation to capturing reopened complaints in Datix Cymru.	2	"Training from the OfWCMS team included a section on how to manage Reopened complaints.	
88	EA/2425-020	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	3	WAST to consider noting a brief consideration of value on Datix Cymru at the outset of every stage of a complaint or claim.	3	"Develop a guidance flowchart to assess whether cases will breach the Redress threshold"	
89	EA/2425-021	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	4	WAST to review the current exclusion from relevant complaint letters of standard paragraphs for Breach of Duty and Qualifying Liability	4	"WAST recognises the potential for changes to the approach around how legal information is provided to complainants as part of the revised PTR Guidance and Concerns Regulations. WAST will review the information it provides on Breach of Duty and Qualifying Liability within its complaints responses. A review paper will drafted for the Executive Team due to the statutory requirement for this information to be provided. "	
90	EA/2425-024	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	7	WAST should ensure the Management of Compensation Claims Policy is updated and subject to periodic reviews	7	"WAST recognises the potential for changes as part of the revised PTR 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."	
91	EA/2425-025	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	8	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	8	"Designate the fields that require completion to provide clarity to staff. "	
92	EA/2425-026	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	8	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	8b	"Development of QA dashboard in Datix to monitor field completion."	
93	EA/2425-027	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	8	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	8c	"Development of regular BI report to provide assurance "	
94	EA/2425-028	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	9	WAST to update the flowchart for the management of inquests and police information requests	9	"Inquest Management SOP to be developed to supersede flowchart (Police information requests are now managed by Records)"	
95	EA/2425-029	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	10	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.	10a	"Designate the fields that require completion to provide clarity to staff."	
96	EA/2425-030	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	10	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.	10b	"Development of QA dashboard in Datix to monitor field completion"	
97	EA/2425-031	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	10	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.	10c	"Development of regular BI report to provide assurance "	
98	EA/2425-032	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	11	WAST to update the Learning from Event Report Standard Operating Procedure to reflect the new process that is being implemented.	11	"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"	
99	EA/2425-033	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	12	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.	12a	"Designate the fields that require completion to provide clarity to staff. "	
100	EA/2425-034	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	12	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.	12b	"Development of QA dashboard in Datix to monitor completion "	
101	EA/2425-035	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	12	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.	12c	"Development of regular BI report to provide assurance "	
117	EA/2526-001	25/26	External Audit	None Set	Public	UEC Arrangements for Managing Demand WASR (April 2025) AW	Not Set	Jonny Sammut (Welsh Ar	Jonny Sammut	n/a	1	"Accuracy of 111 Website 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)."	1	"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 enveloped 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."	

ID	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st Revised Date	2nd Revised Date	3rd Revised Date	Action Status	*ACTION UPDATE	*DATE REVIEWED	*REVIEWED BY	*REVIEW OUTCOME	*LIST OF EVIDENCE SUPPLIED TO SUPPORT PROPOSED CLOSURE	Date of Closure	CorGov Notes
27	31/03/2026	Not Yet Due				Open				Not Set			n/a
28	31/03/2026	Met				Closed in Quarter	25/26 Q3 - Update: **171225** (LT): JC advised action completed. **Proposed for closure**	17/12/2025	Jonathan Chippendale	Completed	- Copy of report 'Clinical Audit Plan Q2 2025/6' presented to QuEST Committee on 04 November 2025 outlining the refinements made the clinical audit action tracking and reporting process.		**210126**: (LT) Evidence supplied > **Closed in Quarter**
29	31/12/2025	Met				Closed in Quarter	2025/26 Q3 Update: **151225 (AK)** - Action completed. **Proposed for closure**	15/12/2025	Claire Appleton / Alison Kelly	Completed	Learning from Deaths AAA Reports (x4) dated:7 January 202518 March 202524 June 202523 September 2025 Learning from Deaths (Mortality Reviews) Reports (x2) dated: Quarters 3 and 4 - March 2024/25Quarters 1 and 2 - 2025/26 Minutes from QuEST Committee Meetings (x2) dated: 2025.05.092025.11.04		210126: (LT) Evidence received to support completion. Closed in Quarter 010825: (LT) Evidence supplied by SP in the forms of committee papers from 3 cycles of business. Awaiting confirmation vi AK that LW happy to support proposed closure of this action. 270625: (LT) Action not yet due. Sarah Parry in P&C advised to link in with AK re: any updates on this action and to supply evidence.
30	30/09/2025	Not Met	31/12/2025			Closed in Quarter	25/26 Q3 Update: **070126 (HB)**: Agreed that AAAs from the IGSG will provide evidence of this on going work with action to be closed. **Closure Proposed**	07/01/2026	Hugh Bennett	Completed	AAA reports from the IGSG (dated July 2025, Sept 2025 and Nov 2025)		**210126**: (LT) Evidence received > **Closed in Quarter**
31	30/09/2025	Not Met	31/12/2025			Closed in Quarter	25/26 Q3 Update: **070126 (HB):** Agreed that AAAs from the IGSG will evidence this on-going work with action to be closed. **Closure Proposed**	07/01/2026	Hugh Bennett	Completed	06/01/26 (AK): IGSG AAAs x3 supplied 02/10/25 (dated Jul25, Sept25, and Nov25)		210126:(LT) Evidence received > **Closed in Quarter**040625: (LT) Confirmed with JC via email that action to remain open until Q2 - action on track for closure in August 2025 as planned.140425: (LT) Q4 update shared with ADLT 260325: (LT) Q4 update received - Action not yet due
74	30/04/2025	Not Met	31/03/2026			Open		07/01/2026	Hugh Bennett	Not Set			040725: (LT) 1st Revised Date (Mar26) applied
75	30/04/2025	Not Met	30/09/2025	31/03/2026		Open			Hugh BE	Not Set			040725: (LT) 1st Revised Date (Sep25) applied
76		Not Set				Open	25/26 Q3 Update **060126** (AK): Deadline for this action to be advised.			Not Set			n/a
77	30/04/2025	Not Met	30/11/2025	31/03/2026		Open	25/26 Q3 Update **060126** (AK): **Proposed revised date of March 2026** due to staff sickness within the PTR Team	06/01/2026	Claire Appleton/Alison Kelly	Date Missed - Revised Date Required			040725: (LT) 1st Revised Date (Nov25) applied
78	31/05/2025	Not Met	31/03/2026			Open				Not Set			040725: (LT) 1st Revised Date (Mar26) applied
79	30/04/2025	Not Met	31/12/2025			Closed in Quarter	25/26 Q3 Update **060126** (AK): **Proposed for Closure**	06/01/2026	Claire Appleton/Alison Kelly	Completed	Putting Things Right Standard Operating Procedure, Data Verification and Assurance Process for Complaints	06/01/2026	210126:(LT) Evidence Received > Closed in Quarter040725: (LT) 1st Revised Date (Dec25) applied
80	31/07/2025	Not Met	31/12/2025	31/03/2026		Open	25/26 Q3 Update **060126** (AK): **Propose a revised date of March 2026** due to staff sickness within the PTR Team	06/01/2026	Claire Appleton/Alison Kelly	Date Missed - Revised Date Required			n/a
81	30/09/2025	Not Met	31/03/2026			Open				Not Set			n/a
82	31/03/2025	Not Met	31/03/2026			Open				Not Set			040725: (LT) 1st Revised Date (Mar26) applied
83	30/04/2025	Not Met	31/03/2026			Open				Not Set			040725: (LT) 1st Revised Date (Mar26) applied
84	31/07/2025	Not Met	31/03/2026			Open				Not Set			n/a
85	31/07/2025	Not Met	31/03/2026			Open				Not Set			n/a
86	31/07/2025	Not Met	31/03/2026			Open				Not Set			n/a
87	31/07/2025	Not Met	31/03/2026			Open				Not Set			n/a
88	30/09/2025	Not Met	31/03/2026			Open				Not Set			n/a
89	30/04/2025	Not Met	31/10/2025			Closed in Quarter	25/26 Q3 Update **060126** (AK): **Propose for closure**	06/01/2026	Claire Appleton / Alison Kelly	Completed	Executive Summary: Welsh Risk Pool Concerns Assessment Recommendations 2024Email dated 11.12.25 from Liam Williams, Executive Director of Quality & Nursing	06/01/2026	210126: (LT) - Evidence received >Closed in Quarter040725: (LT) 1st Revised Date (Oct25) applied
90	31/12/2025	Met				Closed in Quarter	25/26 Q3 Update **060126** (AK): **Proposed for closure.** This recommendation is being mitigated as the draft statutory national guidance states that every organisation must have a Listening to People Policy. This aligns with our already agreed internal proposal that the current Management of Compensation Claims Policy will be superseded by a Listening to People Policy	06/01/2026	Claire Appleton / Alison Kelly	Completed	Email from Lisa Trounce dated 5 September 20205 following a catch up with Claire Appleton, Assistant Director of Putting Things Right	06/01/2026	**210126**: (LT) Evidence received > **Closed in Quarter**
91	28/02/2025	Not Met	31/01/2026			Open				Not Set			040725: (LT) 1st Revised Date (Jan26) applied
92	30/04/2025	Not Met	31/03/2026			Open				Not Set			040725: (LT) 1st Revised Date (Mar26) applied
93		Not Set				Open	25/26 Q3 Update **060126** (AK): Deadline for completion to be advised			Not Set			n/a
94	31/05/2025	Not Met	31/12/2025	30/09/2026		Open	25/26 Q3 Update **070126** (AK): This action cannot be completed owing to changes within Legal Services Team structure. The current SLA comes to an end on 06/02/2026 and it is possible that inquest management will be transferred external to the Trust. We are unable to complete a SOP for this until status of legal provision within/to the Trust is confirmed. This may not be for several months therefore action c/f to 2026/27. **Proposed revised date of September 2026**	06/01/2026	Claire Appleton/Alison Kelly	Date Missed - Revised Date Required			210126:(LT) Explanation supplied re: dependencies >2nd revised date of Sep26 **applied** to allow sufficient time for arrangements from Feb26 onwards to be confirmed and a SOP to be developed reflecting these. **040725**: (LT) 1st Revised Date (Dec25) applied
95	31/03/2025	Not Met	31/10/2025			Closed in Quarter	25/26 Q3 Update **060126 (AK): Proposed for closure.**	06/01/2026	Claire Appleton / Alison Kelly	Completed	Screenshot x 3 of Welsh Risk Pool Inquest Dashboard (the fields on which the Dashboard are built are included in the Dashboard title)Excel spreadsheet 'Stage History Datix Cymru' (spreadsheet provides the range of coding options available to the team under those fields)	06/01/2026	**210126**: (LT) Evidence supplied - **Closed in Quarter040725**: (LT) 1st Revised Date (Oct25) applied
96	30/04/2025	Not Met	31/10/2025			Closed in Quarter	25/26 Q3 Update **060126** (AK): **Proposed for closure**		Claire Appleton/Alison Kelly	Completed	Screenshots of Welsh Risk Pool Inquest Dashboard	06/01/2026	**210126**: (LT) Evidence received > **Closed in Quarter040725**: (LT) 1st Revised Date (Oct25) applied
97		Not Yet Due				Open	25/26 Q3 Update **060126** (AK): Deadline for completion to be advised			Not Set			n/a
98	30/04/2025	Not Set	31/10/2025	31/03/2026		Open	25/26 Q3 Update **060126** (AK): Proposed revised date of March 2026		Claire Appleton/Alison Kelly	Date Missed - Revised Date Required			040725: (LT) 1st Revised Date (Oct25) applied
99	31/03/2025	Not Met	31/01/2026			Open				Not Set			040725: (LT) 1st Revised Date (Jan26) applied
100	30/04/2025	Not Met	31/03/2026			Open				Not Set			040725: (LT) 1st Revised Date (Mar26) applied
101		Not Set				Open	25/26 Q3 Update **060126** (AK): Deadline for completion to be advised			Not Set			n/a
117	31/03/2026	Not Yet Due				Open				Not Set			n/a

116	EA/2026-002	25/26	External Audit	None Set	Public	UEA Arrangements for Managing Demand WAST (April 2025) AM	Not Set	Jonny Sammut (Welsh Av	Jonny Sammut	n/a	2	"Directories of Services 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 36)."	2	"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 envelope and commissioner expectations, which are prerequisites to formal submission. WAST will continue to update any content we own/publish onto to 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."	31/05/2026	Not Yet Due	Open		Not Set	n/a