

## Bundle Reading Room 4 November 2025

Item 19 Audit Tracker Q2 Annexes

Item 19 Audit Tracker Q2 Annex 1 – Audit Tracker 2.0 – 25–26 Q2 Updates – IA up to 23–24 (QuEST)

Item 19 Audit Tracker Q2 Annex 2 – Audit Tracker 2.0 – 25–26 Q2 Updates – IA 24–25 (QuEST)

Item 19 Audit Tracker Q2 Annex 3 – Audit Tracker 2.0 – 25–26 Q2 Updates – EA up to 23–24 (QuEST)

Item 19 Audit Tracker Q2 Annex 4 – Audit Tracker 2.0 – 25–26 Q2 Updates – EA 24–25 (QuEST)

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Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No. in Audit	Recommendation	Action No. in Mgmt Response	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date <small>(NB: Removed / No Longer Available from Apr25)</small>	Closure Status	DIRECTORATE UPDATES Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first
668	23/24	Quest	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Clare Appleton	Iam 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 Datax Cymru.  The All-Wales Patient Safety Policy (NHS Executive) (May 2023) is also due review in March 2024 and will be updated internally when released nationally	Nov 24	Not Met	Dec-25			Open	<b>24/25 Q4 Update</b> 230225 (CA) No further updates have been received for release/implementation date of the revised Putting Things Right Regulations. There is no change to the timescales provided in the last update - action remains on track for completion by W148Dec25.  200125: (LT) ADLT noted 1st revised date (Dec25)  061224: The Putting Things Right Regulations by Welsh Government are yet to be updated. The latest position provided by the Stakeholder Reference Group is for Autumn 2025. The proposal is to move deadline date to December 2025 to allow for Policy rewrite and approval post national release. The NHS Wales Executive have confirmed to the HOPE Network on 27 November 2024 that there is no anticipated revision of the National Patient Safety Incident Policy.
681	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Keith Dorrington	Jonny Sammut	Medium	1.1	To confirm accuracy of the self-certification compliance rate, management should consider capturing the method of training delivery on ESR.	1.1	For future training, the method of instruction will be captured as part of the ESR sign-off process (for example, classroom based, individual learning using the training materials, one to one instruction using the training zone in the application).	Jun-24	Not Met	Sep-24	Mar-25	Apr-26	Open	
683	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Keith Dorrington	Jonny Sammut	Medium	1.3	Management should consider including a test in ESR to confirm competency before successfully self-certifying.	1.3	At the ePCR CRG WAST will discuss including a test to assess understanding at the completion of training.	Jun-24	Not Met	Sep-24	Dec-24	Apr-26	Open	<b>25/26 Q1 Update:</b> 240625 (KD) Please see update recorded against Action 681. Previous 3rd/Final Revised Date amended to Apr26.
684	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Keith Dorrington	Jonny Sammut	Medium	1.4	Whilst we acknowledge there are different methods of training delivery, management should review lower viewed training modules, to confirm that the completed ePCRs are compliant with expectations in this area.	1.4	Through the ePCR Clinical Reference Group (CRG) we will review the lower viewed modules as set out in Appendix B of this report. This will build on knowledge discussed at the most recent ePCR CRG where a small audit has identified that the obstetric section is not being completed. However, we currently have only opened access to the Welsh GP Record (WGPR) for our cohort of Advanced and Senior Paramedics. The pathways section of the ePCR is not currently live and requires testing prior to going live, which explains the disparity reported in these sections of Appendix B.	Sep-24	Not Met	Dec-24	Mar-25	Apr-26	Open	<b>25/26 Q1 Update:</b> 260725 (LT) Previous 3rd/Final Revised Date of May25 amended to Apr26.  240625 (KD) Meeting held with OL (IA) 160625 to discuss remaining ePCR related audit actions and agree a way forward. Clinician metrics: Initial development work is complete on the Tenant structure; we are now building into the application the next phase which is the clinician names next to key interventions. The proposed final go live date for both individuals and managers reporting is 31st March 2026. However, whilst we will report on the above information prior to that date the work is very much iterative and continual development will be required.
686	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Keith Dorrington	Jonny Sammut	High	2.2	Management should ensure the tenant structure is developed to provide data at both a team and individual level to assist in identifying training needs and drive improvement in ePCR compliance.	2.2	Reporting into CIAG, we will set up a Task and Finish Group to write the plan to deliver the dashboards against the Tenant Structure. This is a complex piece and requires input from multiple directorates. It is also dependent on the capacity within teams to deliver the dashboards, therefore the output of the T&F might be a business case jointly developed between the Digital and Clinical Directorates to outline the resources required and what this would cost to deliver.	Sep-24	Not Met	Mar-25	Sep-25	Apr-26	Open	<b>25/26 Q2 Update:</b> 221025 (LT): When the outstanding actions relating to this audit were discussed earlier in the year, the completion date for this action remained unchanged. In hindsight this should have been extended to April 2026 in line with the other three remaining actions. Therefore, as an exception, a 3rd Revised Date (Apr26) has been applied.  021025 (KD): The Clinical Tenant structure is complete, Operations have now requested that we build a structure aligned to the DOM's team makeup. completion of this build is November 2025. There will be further work needed on the portal frontend to allow the movement of teams members. completion of this element is due Jan 2026.
701	23/24	Quest	Clinical Audit	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.1	The Trust should ensure appropriate detail in relation to clinical audit is included and documented it within its organisational documents.	1.1	There are workshops scheduled (4th, 9th and 10th July 2024) to plan the next iteration of the Trust clinical strategy. The Clinical Directorate will ensure that clinical audit is given the space it needs to articulate the need for, and link to the guidelines on how to undertake an audit in the final approved document. Where update presentations are given up to, and including, board level meetings, the Clinical Directorate will ensure clinical audit is included. The clinical strategy will articulate clearly how clinical audit meets HQIP standards and will link to the clinical audit plan (for example, to the Clinical Audit section on the Trust intranet).	Mar-25	Not Met	Jun-25	Sep-25		Closed in Quarter	<b>25/26 Q2 Update:</b> 240925 (JL): Proposed for closure. Evidence supplied: CIA Clinical Plan.

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044-24/25	2024/25	QuEST	Patient Experience & Community Involvement	Reasonable	Leanne Hawker	Liam Williams	Medium	3.1	The PEI team's work plan should be reviewed to better define and coordinate their activity.	1.1 (3)	PEI team to devise a proforma for directorates and quality improvement programmes/projects to request support and involvement to their scheme of work.	Apr-25	Not Met	TBA			Open	25/26 Q2 Update: 290925 (LT) Revised completion date to be advised following November 2025 QuEST meeting. Statement supplied by Executive Director of Quality and Nursing contained within Q2 Audit Reports to QuEST and ARAC.
045-24/25	2024/25	QuEST	Patient Experience & Community Involvement	Reasonable	Leanne Hawker	Liam Williams	Medium	3.1	The PEI team's work plan should be reviewed to better define and coordinate their activity.	1.1 (4)	PEI 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 PEI team can support increased improvements in outcomes.	Aug-25	Not Met	TBA			Open	25/26 Q2 Update: 250925 (AK): This date will be revised pending the outcome of the revised PEI structure. Statement supplied by Executive Director of Quality and Nursing is reflected within the audit reports to QuEST and ARAC.
048-24/25	2024/25	QuEST	Patient Experience & Community Involvement	Reasonable	Leanne Hawker	Liam Williams	Medium	3.1	The Team should continue its work to increase survey responses to ensure there is significant level of response, to provide a level of assurance that responses reflect the views of the public.	3.1 (2)	Liaising with Fleet to explore use of QR Codes on vehicles to enable patients/families to access feedback surveys whilst waiting.	Mar-25	Not Met	Jul-25	Mar-26		Open	25/26 Q2 Update: 150925 (AK): Fleet Dept has requested that a paper be submitted to the Fleet SDP Delivery Group to gain formal approval and to be sighted on senior leadership support within the Quality, Safety & Patient Experience Directorate for this work. Proposed revised date of March 2026 to take into account winter pressures.
059-24/25	2024/25	QuEST	Roll-out of Pentrox	Reasonable	Judith Bryce / Huw Jackson	Andy Swinburn	Medium	1	<b>CFR Access to Replenish Pentrox Supply</b> Not all CFRs have access to either the Omnicell cabinets or the Pentrox Safes to replenish stock levels after use. To replenish the CFR requires a senior Trust employee (usually a DOM) to meet them at an Omnicell Cabinet or Pentrox safe to gain access and replenish supply.  Further, the Pentrox safes require Abloy keys to gain access. To date, only seven DOMs on the Abloy records have access.	1	CFR leads are required to confirm the names and PIN of all current CFRs, to allow the Medicines Management team to check them against those CFRs already on the Omnicell system.  North Wales Locality Managers to update the names and pay/ESR numbers of all DOMs that require access to the Pentrox safes. This will allow the Medicines Management team to check them against DOMs that already have the Pentrox access permission on their Abloy keys.	May-25	Not Met	Oct-25			Open	25/26 Q2 Update: 240925: (JL) Update to be provided in October 2025 (Q3) as RO and workstream lead are on leave.
077-24/25	2024/25	QuEST	Risk Management & Board Assurance Framework	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.  <b>Risk &amp; Impact:</b> 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.  <b>Expected Evidence of Implementation:</b> Updated suite of Risk Management documentation.	Mar-26	Not Yet Due				Open	.
079-24/25	2024/25	QuEST	Emergency Communication Nurse System (ECNS) Implementation	Reasonable	Jonathan Edwards	Lee Brooks	High	2	<b>ECNS Audit Arrangements</b> Capacity constraints within the PPE team (currently 2.8WTE) has resulted in delays in completion, with December 2024 audits still to be completed as at April 2025, resulting in a backlog in excess of 400 audits.  The need to review the operational capacity of the PPE team has been recognised by integrated Care management, and a business case to secure dedicated ECNS auditors within an Operations Quality team (within the Emergency Medical Service Co-ordination structure) has been approved, although a timescale of implementation was not available at time of audit fieldwork.  <b>Theme:</b> Resourcing <b>Risk &amp; Impact:</b> Continued lack of capacity to deliver audits could result in loss of accreditation.	2	<b>Agreed Action:</b> The Trust will have the uplifted number of 6 ECNS auditors in place in Q2 of 25/26 financial year. This uplift will be commensurate with the levels agreed in the business case.	Sep-25	Met				Closed in Quarter	25/26 Q2 Update: 230925 (TMM) The Operations Quality OCP - Operations Quality OCP consultation period finished on 05 Sept and the final consultation document will be released this week. Implementation phase commences on 22 September 2025. The Quality Audit (Clinical) JD has been matched and CAJE'd and recruitment can begin end of Sept 2025. PROPOSE CLOSURE
080-24/25	2024/25	QuEST	Emergency Communication Nurse System (ECNS) Implementation	Reasonable	Andrew Garner	Lee Brooks	Medium	3	<b>ECNS Audit Report Format</b> Review of audit reports confirmed that they provided a mix of recognition of good practice alongside areas where corrective feedback was required. IAED performance standards notes that when providing feedback there should be focus on the exact performance that did not meet the standard.  Our review of 30 audit reports noted that 13 did not reference the performance standard where an issue had been identified, and 17 did not indicate the categorisation of deviation.  Currently audit reports are circulated via email to the clinician and line manager, however, there is no requirement for receipt or acknowledgement of content.  <b>Theme:</b> Performance Monitoring <b>Risk &amp; Impact:</b> Unclear and delayed feedback impact on the value and ability to influence practice of audits.	3	<b>Agreed Action:</b> Quality Audit realigned to Operations Quality and bespoke job description being created to appoint into permanent Quality Audit (Clinical) posts. Operations Quality to have management and leadership oversight. Levelling to be undertaken to set out expectations for inclusion of all required information such as performance standards and deviation categories and a request to support levelling will be made to the International Academies of Emergency Dispatch (IAED).  Consideration will be given more widely on how to ensure monitoring of receipt of feedback and respective managers/focal management teams updated.  <b>Expected Evidence of Implementation:</b> Quality assurance processes will be developed and refined internally, and the IAED Accredited Centre of Excellence (for which the Trust has for ECNS) sets out required standards which will be monitored closely in monthly compliance reports, submitted to the IAED and internally monitored by the Integrated Care Quality Meeting which reports onward into the Senior Operations Team (SOT).	Dec-25	Not Yet Due				Open	25/26 Q2 Update: 290925 (TMM) Forms part of the Operations Quality OCP and recruitment will begin shortly now this has been completed. Operations Quality will work with Integrated Care and the IAED to refine and agree processes and providing assurances in the Integrated Care Quality Meeting. Reports will be developed and refined once this team is in place to ensure operational teams are receiving the required information and assurance on quality monitoring. On track for December, however, will be evolving over time.

081-24/25	2024/25	QuEST	Emergency Communication Nurse System (ECNS) Implementation	Reasonable	Peter Brown	Lee Brooks	High	4	<p><b>ECNS Monitoring Arrangements</b></p> <p>The QAF and IAD performance standards include the need for ongoing monitoring of individual clinician performance on a routine basis. A locally held spreadsheet has been developed to support this due to constraints within the AQUA reporting tool and need for cleansing of prior user data.</p> <p>Inconsistencies were noted when comparing this spreadsheet to AQUA generated reports regarding the clinicians included (10 identified as receiving audits but not detailed within the spreadsheet) and the number of audits recorded (only one out of six months totalling the required 132 audits).</p> <p>Additionally, we identified:</p> <ul style="list-style-type: none"> <li>- six clinicians yet to receive audits, and</li> <li>- on average, 44% of CSD clinicians did not receive an audit each month within our sample period June 2024 – November 2024.</li> </ul> <p><b>Theme:</b> Performance Monitoring</p> <p><b>Risk &amp; Impact:</b> Control Operation</p>	4	<p><b>Agreed Action:</b> A review will be conducted to move to a single monitoring mechanism with appropriate data cleansing processes. The reporting mechanism will be embedded into Integrated Care Quality Meeting (ICQM) and through the Senior Ops Governance Structure along with CQGG. Those not in receipt of an audit are being prioritised.</p> <p><b>Expected Evidence of Implementation:</b> AQUA Reporting will be the primary methodology used to report compliance.</p>	Sep-25	Met			Closed in Quarter	<p><a href="#">25/26 O2 Update:</a></p> <p>120925 (TMM) A review has been conducted to transition to a single monitoring mechanism for ECNS, with AQUA system data now established as the sole source. Appropriate data cleansing processes have been embedded, including regular updates via PPD meetings and improved communication with the integrated care management team. The reporting mechanism is now formally embedded into the Integrated Care Quality Meeting, ensuring ongoing oversight and accountability.</p> <p><b>PROPOSED CLOSURE:</b> Evidence supplied: IC Quality Assurance AAA 21.08.25 v1</p>
082-24/25	2024/25	QuEST	Emergency Communication Nurse System (ECNS) Implementation	Reasonable	Jonathan Edwards	Lee Brooks	Medium	5	<p><b>ECNS Performance Development Plans</b></p> <p>Where a clinician is identified as 'below a performance threshold' the QAF outlines a performance development plan (PDP) structure to be applied to offer action plans which include additional support, enhanced audits and further escalation where improvement is not achieved.</p> <p>At present, due to the lack of capacity within the PPE team to undertake additional audits, the PDP process is not actively practiced. However, we were advised that local management will engage with ECNS users on wider performance issues. The limitations in coverage and number of clinicians receiving regular audits (see key finding 4) also impacts the effectiveness of the PDP process in identifying those who require additional support.</p> <p><b>Theme:</b> Performance Monitoring</p> <p><b>Risk &amp; Impact:</b> Lack of mechanisms to address continued non-compliance</p>	5	<p><b>Agreed Action:</b> As per the agreed action for Key Finding 2 the Trust will have the uplifted number of ECNS auditors in place in Q2 of 25/26 financial year. This uplift will be commensurate with the levels agreed in the business case. This will enable the required levels of audits.</p> <p><b>Expected Evidence of Implementation:</b> The uplifted levels will be evidenced through establishment reports.</p>	Sep-25	Met		Closed in Quarter	<p><a href="#">25/26 O2 Update:</a></p> <p>120925 (TMM) The Operations Quality OCP: Operations Quality OCP consultation period finished on 05 Sept and the final consultation document will be released this week. Implementation phase commences on 22/09/2025. The Quality Audit (Clinical) ID has been matched and CAIE'd and recruitment can begin end of Sept 2025.</p> <p><b>PROPOSED CLOSURE</b></p>	
083-24/25	2024/25	QuEST	Emergency Communication Nurse System (ECNS) Implementation	Reasonable	Mike Brady	Lee Brooks	Medium	6	<p><b>Periodic Benefit Assessment</b></p> <p>We could not identify any post implementation review, or subsequent assessment of the system benefits since the closure of the project. As such the Trust will not be sighted on the system impacts, outcomes and progress towards benefit realisation.</p>	6	<p><b>Agreed Action:</b> The Trust accepts this finding and agrees with the necessity for clearer benefits assessment milestones at the beginning of such programmes. The majority of benefits were, however, fully realised upon implementation. Consequently, ongoing periodic benefits assessments were not planned. The later rapid addition of 28 full-time clinicians, while helpful, shifted focus and changed baseline operational benefits of other metrics, due to new and rotating CSD staff and demand-capacity adjustments.</p> <p>Operational measures are now monitored through existing mechanisms.</p> <p>The Trust will develop a clear table of evidence outlining which benefits have been achieved on implementation (how and why) and which outstanding benefits require more work or are now being monitored through existing mechanisms or link to existing agreed actions within this audit.</p> <p><b>Expected Evidence of Implementation:</b> Development of a table of ECNS benefits with outline of evidence or monitoring.</p>	Sep-25	Met		Closed in Quarter	<p><a href="#">25/26 O2 Update:</a></p> <p>230925 (TMM) Following on from a meeting with Audit Wales, work has been undertaken with the team to produce a draft table to receive feedback comments on the proposed benefits. This version of the draft is being submitted internally for review.</p> <p><b>Propose Closure.</b></p>	
101-24/25	2024/25	QuEST	Start of Shift Procedure	Limited	Sonia Thompson	Lee Brooks	Medium	1	<p><b>Awareness of SOP</b></p> <p>In February 2025, as part of the Quality &amp; Support days, Ambulance Care focused on enhancing the operational efficiency and safety of ambulance services, particularly through the lens of Shift Start and Vehicle Security during shifts.</p> <p>Weaknesses were noted in relation to awareness of the SOP, as well as completion of expected forms (see key finding 3) and the time taken to be taken to complete the checks.</p> <p>As has been reported within the Operations Quarterly Sub-Report (Q4) such has highlighted a training need. Whilst it is appreciated these results are specific to Ambulance Care, consideration should also be given to understanding the current practices applied within EMS to confirm awareness of the SOP.</p>	1	<p>Communications will be circulated to reinforce the SOP and its contents. The timing of this will coincide with the release of an updated SOP (as reflected in Key Finding 2).</p> <p><b>Expected Evidence of Implementation:</b> Copy of the communications.</p>	Oct-25	Not Yet Due		Open	<p><a href="#">25/26 O2 Update:</a></p> <p>240925 (TMM) Necessary changes will be made to the SOP following workshops on overruns and ongoing work with VDI checking. Following this, the SOP will be circulated.</p>	
102-24/25	2024/25	QuEST	Start of Shift Procedure	Limited	Ben Collins	Lee Brooks	Medium	2	<p><b>Update to SOP to reflect current practices</b></p> <p>As detailed within the SOP for Start of Shift arrangements, 'staff must complete their legal VDI checks (Appendix 1) to comply with the Road Traffic Act, prior to mobilising any call.'</p> <p>As reported from a recent Quality &amp; Support day, only 50% of those in Ambulance Care are completing the forms alongside the acknowledgments included in the MDVS, with the rest only using the MDVS. However, there is no reference to MDVS within the SOP which could raise confusion as to whether such is a supplement to, or replacement for, the VDI checks.</p> <p>Further, whilst the headings as per the MDVS correlate with the primary checks as included in the VDI form, the latter provides more detail/guidance for the driver completing.</p> <p>It is also noted that, as a result of the recent Quality &amp; Support Day, (see objective 5) there is a need to update the SOP to align with the needs of the NEPTS/Ambulance Care teams to 'ensure that all staff regardless of their specific roles are on the same page regarding shift commencement procedures.'</p>	2	<p>The Vehicle Accident Management Task &amp; Finish Group are currently reviewing VDI processes within the Trust in line with the Vehicle Accident Management Internal Audit actions. Given the correlation with this audit, the scope of this group will be expanded to include Start of Shift SOP arrangements. On agreement of the new process from the Task &amp; Finish Group, the SOP will be updated to reflect current practice. Senior Operations Team (SOT) will maintain oversight and responsibility of this audit action.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- AAA reports from the Task &amp; Finish Group to confirm agreed process;</li> <li>- copy of updated SOP to reflect practice, and</li> <li>- copy of AAA to approve amended SOP.</li> </ul>	Oct-25	Not Yet Due		Open	<p><a href="#">25/26 O2 Update:</a></p> <p>240925 (TMM) The process of VDI is still being discussed in the T&amp;F Group, an options appraisal has been developed in draft however further discussions may confirm that an appraisal is not needed for VDI process. Further information being sought.</p>	

103-24/25	2024/25	QuEST	Start of Shift Procedure	Limited	Ben Collins	Lee Brooks	High	3	<p><b>Lack of evidence to demonstrate compliance of checks</b></p> <p>As has been identified through the recent Ambulance Care Quality &amp; Support day, 50% of the staff involved (circa 162) completed the paper-based forms as per the SOP. It is not clear as to the completion rate for EMS as such was not the focus for their Quality &amp; Support day; however, the site visits undertaken during the course of audit fieldwork noted that no forms were completed and retained post completion of the checks.</p> <p>Recognising the legal requirement for the completion of these checks, and wider compliance with the SOP, consideration should be given to the development of an electronic version of the VDI form, to be made available via the iPads. The receipt into a central mailbox / repository would allow for a date/time stamp to be actioned therefore providing an opportunity to understand the timeframe for completion amongst crews – the output of which can be reported and escalated as appropriate.</p> <p>Consideration could also be given to the inclusion of sign off for clinical and equipment checks noting there is no specified requirement, as per the SOP, for such to be documented (see objective 5).</p>	3	<p>The Vehicle Accident Management T&amp;F Group are currently reviewing VDI processes within the Trust in line with the Vehicle Accident Management Internal Audit actions, this includes the process to demonstrate compliance and reporting of checks. Given the correlation with this audit, the scope of this group will be expanded to include Start of Shift SOP arrangements. SOT will maintain oversight and responsibility of this audit action.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- AAA reports from the Task &amp; Finish Group to confirm discussions on the VDI process and reporting mechanisms, and</li> <li>- an updated version of the SOP</li> </ul>	Oct-25	Not Yet Due			Open	<p><a href="#">25/26 O2 Update:</a> 260925 (TMM) The process of VDI is still being discussed in the T&amp;F Group, an options appraisal has been developed in draft however further discussions may confirm that an appraisal is not needed for VDI process. Further information being sought.</p>
104-24/25	2024/25	QuEST	Start of Shift Procedure	Limited	Sonia Thompson & Mark Harris	Lee Brooks	Medium	4	<p><b>Review of Consumables</b></p> <p>There is a minimum list of expected consumables and equipment to be retained on EMS and Ambulance Care vehicles. Noting the lesser amount on the latter it is easier to maintain a regular stock check of the items.</p> <p>However, with EMS, there is the risk that crew members will pick up what they think is needed within the time period available to complete the check rather than there being a routine stock count completed, which will also pick up expiry dates for items.</p> <p>We appreciate that consumables review will be undertaken on behalf of the paramedics at MRD; however consideration should be given to a regular scheduled review of consumables at the stations or through the MRD as part of the wider cleaning schedule to rationalise the consumables held and prevent wastage / excessive ordering.</p>	4	<p>The Trust accepts this finding and recognises that whilst there is a list of minimal consumables in MRD this currently is not applied at ambulance stations. The Operations Directorate will share comms to staff on the minimal list of consumables required for Vehicles to reinforce the amount that needs to be held. The list will also be placed on all relevant vehicles. Consideration will also be given to incorporate a regular scheduled review of consumables.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- A copy of list of consumables that will be added to vehicles,</li> <li>- a copy of the comms to reinforce the consumable amounts</li> <li>- AAA report from EMG (EMS Management Group)</li> <li>- AAA report from Ambulance Care Service Management Meeting to confirm discussions on scheduled review consideration.</li> </ul>	Oct-25	Not Yet Due			Open	<p><a href="#">25/26 O2 Update:</a> 150925 (TMM) The list of consumables along with a bulletin will be circulated the same time as the amended SOP. (ref action 101-24/25)</p>
105-24/25	2024/25	QuEST	Start of Shift Procedure	Limited	Ben Collins	Lee Brooks	High	5	<p><b>Reporting</b></p> <p>There is no evidence of routine reporting being undertaken to measure compliance with the SOP, timeliness and accuracy of completion to permit escalation of concerns, should they be identified.</p> <p>Whilst the output of the Quality &amp; Support day has been reported at Committee level, this related to an exercise completed in quarter 4 and was only in relation to Ambulance Care.</p> <p>The use of a central repository for completed forms (see Key Finding 3) would help facilitate reporting.</p>	5	<p>EMG (EMS Management Group) will review the main key points of the SOP and potential compliance measurements and will complete a dip sample exercise based on the key components to review compliance and discuss next steps to include regular routine reporting. SOT will maintain oversight and responsibility of this audit action.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>- AAA reports from EMG (EMS Management Group) into SOT (Senior Operations Team) to determine discussions on the SOP, and</li> <li>- the results of the dip sample / next steps discussions.</li> </ul>	Dec-25	Not Yet Due			Open	<p><a href="#">25/26 O2 Update:</a> 150925 (TMM) Following the workshops on Overruns, Departmental Actions Cards are being created which will allow departments to measure outcomes of the SOP requirements.</p>

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Trust Ref No.	Audit Wales or HW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No. in Audit	Recommendation	Action No. in Mgmt Response	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date (Nil: Removed / No Longer Available from Apr25)	DIRECTORATE UPDATES Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first	Closure Status
155	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Kate Blackmore, Assistant Director of Quality Governance	Liam Williams		R2	<b>Quality Strategy Monitoring</b> There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports:  2.1 Provide timescales for the expected delivery of each action;  2.2 Differentiate between the progress of individual actions and strategic outputs, and  2.3 Ensure that progress reports are reported regularly and are included in the QuEST cycle of business.	R2	The approved Quality Plan will be supported by a robust implementation plan clearly articulating measurable actions and timescales for delivery against responsible and accountable owners.  Updates will be provided via the governance structures to ensure regular updates are provided to QuEST via the cycle of business.  The Assistant Director of Quality Governance will work with Corporate Governance leaders to ensure a clear cycle of updates and escalation is included within the implementation plan.  The review of minutes from QuEST Committee which includes these progress reports, through four cycles of business, will close this action.	Mar-26	Not Yet Due					Open
156	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Vince Bagloe, Head of Clinical Intelligence & Assurance	Liam Williams		R3	<b>Clinical Audit Plan</b> There are opportunities to further enhance reports on the Trust's Clinical Audit function, by:  3.1 More clearly highlighting any changes made to the approved Clinical Audit Plan; and  3.2 Capturing key findings, outcomes and learning from completed audits.	R3	We will review the communication lines between 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.	Mar-26	Not Yet Due				Open	
159	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Claire Appleton, Assistant Director of Putting Things Right	Liam Williams		2022 - R3 (3.1)	<b>Mortality Reviews</b> The QuEST Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuEST Committee receives quarterly update reports to include:  3.1 the number of reviews undertaken, and the numbers of reviews required but not yet complete.	2022 - R3 (3.1)	The learning from deaths forum and associated sub groups Terms of Reference include the sharing of learning at a local level as well as contributing to learning on a national basis.  This information is shared via the Alert, Advise, Assure (AAA) highlight report. The content of the highlight report will be reviewed through governance processes to ensure consistency of reporting aligned to the Agendas of these fora.  Four highlight reports which include this consistency of data alongside QuEST committee minutes will close action 3.1	Dec-25	Met				Open	
167	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Hugh Bennett, Assistant Director of Commissioning & Performance	Liam Williams		2022 - RB (8.3)	<b>Quality Performance Reporting and Learning</b> We found that the QuEST Committee is well served with quality information, but there are opportunities for improvement. The Trust should:  8.3 work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits.	2022 - RB (8.3)	Whilst we remain limited by data accessibility we continue to pursue patient outcome data through ePCR as well as linking our critical systems to the Welsh Demographic Service allowing the first steps into linking remote clinical assessment with patient outcomes. The ability to achieve truly robust outcome measures without data linkage is limited, we continue to work with DHCW to resolve barriers to data sharing across NHS Wales.  Three Alert, Advise, Assure (AAA) Highlight reports from Information Governance Steering Group will provide evidence of this ongoing work and will close both action 8.3 and 8.4	Sep-25	Not Met	Dec-25		<b>25/26 O2 Update:</b> 221025 (LT): Responsible Owner (HB) requested action remain open for further 3mths. Based on update supplied, 1st revised date (Dec25) applied  <b>011025 (AK):</b> Preliminary evidence provided: Information Governance Steering Group AAA Report to Executive Leadership Team for meetings held on 26 November 2024; 11 July 2025 and 22 September 2025  <b>25/09/25 (HB):</b> ROSC reporting is now live at a health board level (linked to Purple go live) and various new clinical indicators for Emerg will come on stream in Q3, however, full data linkage is a national issue, which WAST cannot resolve on its own and is unlikely to be resolved over the next three months.	Open	
168	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Hugh Bennett, Assistant Director of Commissioning & Performance	Liam Williams		2022 - RB (8.4)	<b>Quality Performance Reporting and Learning</b> We found that the QuEST Committee is well served with quality information, but there are opportunities for improvement. The Trust should:  8.4 develop patient outcome measures to support its existing quality measures	2022 - RB (8.4)	Whilst we remain limited by data accessibility we continue to pursue patient outcome data through ePCR as well as linking our critical systems to the Welsh Demographic Service allowing the first steps into linking remote clinical assessment with patient outcomes. The ability to achieve truly robust outcome measures without data linkage is limited, we continue to work with DHCW to resolve barriers to data sharing across NHS Wales.  Three Alert, Advise, Assure (AAA) Highlight reports from Information Governance Steering Group will provide evidence of this ongoing work and will close both action 8.3 and 8.4	Sep-25	Not Met	Dec-25		<b>25/26 O2 Update:</b> 221025 (LT): Responsible Owner (HB) requested action remain open for further 3mths. Based on update supplied, 1st revised date (Dec25) applied.  <b>011025 (AK):</b> Preliminary evidence provided: Evidence Provided: 1. Information Governance Steering Group AAA Report to Executive Leadership Team for meetings held on 26 November 2024; 11 July 2025 and 22 September 2025  <b>25/09/25 (HB):</b> ROSC reporting is now live at a health board level (linked to Purple go live) and various new clinical indicators for Emerg will come on stream in Q3, however, full data linkage is a national issue, which WAST cannot resolve on its own and is unlikely to be resolved over the next three months.	Open	

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157	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Kate Blackmore, Assistant Director of Quality Governance	Liam Williams		R4	<b>Duty of Candour and Quality Training</b> The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements.	R4	Access to both Duty of Quality and Duty of Candour training is available via ESR with Duty of Quality training also available via Learning@Wales.  It is important to balance not just the compliance to the training request but also the impact that training has.  In order to increase uptake rates the Duty of Quality training content has been duplicated onto Learn365 which allows the training to be more accessible and stress-free increasing uptake and engagement. Quality Management Group are now monitoring a similar approach for the Duty of Candour training.  Engagement with the training is monitored via the Education and Development Team as well as by the Quality Management Group. Local teams will receive regular updates on their compliance with this training and will receive support via QMG on how to improve uptake rates of training.  Highlight reports from QMG to CQGG which include the actions taken to increase uptake rates alongside the current completion rates across the organisation will close this action. This will be demonstrable through three Alert, Advise, Assure (AAA) Highlight reports.	Sep-25	Met				<a href="#">25/26.02 Update:</a> <a href="#">150925 (AK): Proposed for closure</a>  Evidence supplied: 1. Quality Management Group AAA for Cycle 22 submitted to the Clinical & Quality Governance Group 12.6.25 (Ref 3.2) 2. Quality Management Group AAA for Cycle 23 submitted to the Clinical & Quality Governance Group 24.7.25 (Ref 4.2) 3. Quality Management Group AAA for Cycle 25 submitted to the Clinical & Quality Governance Group 29.9.25 (Ref 3.2)	Closed in Quarter
164	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Sara Mills, Head of Culture and Organisational Development	Liam Williams		2022 - R5	<b>Personal Appraisal and Development Reviews (PADR)</b> The Trust has low PADR compliance rates, for example in June 2022 the Trust's compliance was 59% against the 85% target. As part of embedding its new behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.	2022 - R5	We are implementing a range of measures aimed not only at increasing compliance but also at enhancing the quality and value of PADR conversations. The Trust is committed to improving PADR compliance while also ensuring that these reviews provide real value to staff and managers. We will continue to monitor progress and adjust our strategies as necessary, while also considering how our target metrics or measures of success can better reflect our commitment to meaningful and impactful conversations.  Minutes of People & Culture committee where updates are received regarding compliance to target and actions taken to improve the value to staff and managers across three cycles of business will close this action.	Dec-25	Met				<a href="#">25/26.02 Update:</a> <a href="#">150925 (AK): Proposed for closure</a>  Evidence Supplied via Agenda and minutes from People and Culture Committee: November 2024 Meeting: Page 46 Ref P&C Metrics SBAR (Agenda) and Page 9 Ref 95/24 (Minutes) February 2025 Meeting: Page 105 Ref P&C Metrics SBAR (Agenda) and Page 13 Ref 130/24 (Minutes) May 2025 Meeting: Page 87 Ref P&C Metrics SBAR (Agenda) and Page 8 for minutes	Closed in Quarter
165	Audit Wales	23/24	QuEST	Quality Governance Follow Up Review	Hugh Bennett, Assistant Director of Commissioning & Performance	Liam Williams		2022 - R8 (8.1)	<b>Quality Performance Reporting and Learning</b> We found that the QuEST Committee is well served with quality information, but there are opportunities for improvement. The Trust should:  8.1 develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. measures	2022 - R8 (8.1)	Through our Quality Performance Management Framework we will explore how we can draw focus across departments and directorates to triangulate information identifying themes for learning and improvement. This will be used either for internal continual improvement where this is within our boundaries or to share as part of external collaborative working both with health boards and commissioners. Committee	Sep-25	Met				<a href="#">25/26.02 Update:</a> <a href="#">011025 (AK): Proposed for closure</a>  Evidence provided: 1. Quality, Patient Experience & Safety Committee minutes for 4 February 2025 2. Quality, Patient Experience & Safety Committee minutes for 9 May 2025  <a href="#">250925 (H8) The Monthly Quality &amp; Improvement Report (MIQPR)</a> provides +200 indicators, using a balanced scorecard approach and inter-connected graphs and combination graphs. It provides a strong analytical tool for triangulation.	Closed in Quarter

**Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With an Orange Header**  
**When reporting a recommendation as closed, please detail and supply email evidence to support this, clearly stating the recommendation in the email.**  
**When proposing a revised date, please include the rationale for the movement and any progress on the action to date**  
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Trust Ref. No.	Audit Wales, HW or Other Report	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No in Audit	Recommendation	Action No. in Mngt Response	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	Closure Status	DIRECTORATE UPDATES Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date
EA/2425-004	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R01	2023-R01	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru	2023-R01(a)	Make additions to Adverse Incident SOP so that responsibilities for QA upon closure of incident records is clear. Self assessment for each service area should be built into their Departmental Quality Performance Management Framework	Apr-25	Not Met	Mar-26	Open	<a href="#">25/26 Q1 Update:</a> 180625 (TT) Proposed revised date of March 2026 to ensure that all teams across the organisation have had an opportunity to undertake QA Self Assessment and ensure delivery of the QPMF Self Assessment in line with QPM Steering Group Workplan timelines. SOP updated and awaiting approval. QA Self Assessment Guidance has been reviewed and updated by QA Lead.	
EA/2425-005	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R01	2023-R01	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru	2023-R01(b)	Work with the Once for Wales Central Team to design listing reports which can be cascaded to service areas identifying records which need to be re-opened and adjusted or additional information provided	Apr-25	Not Met	Sep-25	Mar-26	Open	<a href="#">25/26 Q2 Update:</a> 221025 (LT) 2nd Revised Date of Mar26 applied, therefore Executive Director of Quality and Nursing to be asked to attend ARAC on approval for recommended assurance. 250925 (AK) Propose a revised date of March 2026 due to capacity challenge; (acknowledges) within the Putting Things Right Team.
EA/2425-006	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R01	2023-R01	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru	2023-R01 (c)	Develop and deploy Robotic Process Automation to identify incomplete/ inappropriately completed records and report this information by exception report to the Quality Management Group to monitor performance.	TBA (Dependent on in year Digital priorities)	Not Yet Due			Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Scoping Meeting arranged with Assistant Director of Digital Services: Digital Transformation & Innovation for September 2025
EA/2425-007	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R02	2023-R02	WAST should introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary	2023-R02(a)	Make additions to Adverse Incident SOP to ensure that timescales for reviewing new incidents, undertaking investigatory work and closing records is clear for all staff.	Apr-25	Not Met	Nov-25	Open	<a href="#">25/26 Q1 Update:</a> 180625 (TT) Proposed revised date of November 2025 to allow for further discussion at Data Governance Group on approvals for recommended timescales before SOP can be updated	
EA/2425-008	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R02	2023-R02	WAST should introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary	2023-R02(b)	Heads of Service to develop Improvement Strategies for incident closures which will be monitored through service focus area Quality Management Group	May-25	Not Met	Mar-26	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Proposed revised date of March 2026	
EA/2425-010	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R04	2023-R04	The process for obtaining consent for the release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.	2023-R04(a)	SOP to be reviewed for current accuracy and then approved by Senior Quality Team	Apr-25	Not Met	Dec-25	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Proposed revised date of December 2025	
EA/2425-011	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R04	2023-R04	The process for obtaining consent for the release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.	2023-R04(b)	Commence Quarterly Complaints Audit to provide assurance that SOP is being followed.	Jul-25	Not Met	Dec-25	Open	<a href="#">25/26 Q2 Update:</a> 250925 (AK) Propose a revised date of December 2025 to allow the team to undertake a full quarters audit	
EA/2425-013	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R06	2023-R06	It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach	2023-R06(b)	Senior Quality Team to undertake options appraisal of digital action planning software to enhance organisational assurance in respect of action plan completion	Sep-25	Not Met	Mar-26	Open	<a href="#">25/26 Q2 Update:</a> 250925 (AK) Proposed revised date of March 2026 due to staff sickness in the Putting Things Right Team.	
EA/2425-014	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R06	2023-R06	It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach	2023-R06(c) i	In order to set an achievable target within a continuous improvement journey, focus in the next year will be prioritised on how YCF are being 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.	Mar-25	Not Met	Mar-26	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Proposed revised date of March 2026	
EA/2425-015	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R06	2023-R06	It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach	2023-R06(c) ii	WAST to support workshop for OIWCMS Incident Workshop to provide enhanced definitions and guidance for YCF and ensure ambulance leaders can utilise it more confidently	Apr-25	Not Met	Mar-26	Open	<a href="#">25/26 Q1 Update:</a> 300625 (CA) Proposed revised date of March 2026	
EA/2425-016	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R09	2023-R09	WAST should ensure subject and sub-subject codes for all records in the Datix Cymru systems are completed consistently and comprehensively and are subject to validation checks	2023-R09	This recommendation was addressed through the development of a Complaints Validation SOP. The SOP has taken time to embed due to OCP and recruitment across the PTR & Legal Services Department.  Commence Quarterly Complaints Audit to provide assurance that SOP is being followed.	Jul-25	Not Met	Mar-26	Open	<a href="#">25/26 Q2 Update:</a> 250925 (AK) Proposed revised date of March 2026 due to staff sickness in the Putting Things Right Team.	
EA/2425-017	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R10	2023-R10	WAST should ensure the description field is completed correctly on the Datix Cymru system and that these are subject to validation checks.	2023-R10	This recommendation was addressed through the development of a Complaints Validation SOP. The SOP has taken time to embed due to OCP and recruitment across the PTR & Legal Services Department.  Commence Quarterly Complaints Audit to provide assurance that SOP is being followed.	Jul-25	Not Met	Mar-26	Open	<a href="#">25/26 Q2 Update:</a> 250925 (AK) Proposed revised date of March 2026 due to staff sickness in the Putting Things Right Team.	
EA/2425-018	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R01	R01	WAST to ensure that inclusion of additional contacts, where appropriate, is undertaken in relevant complaint records. An audit process may provide assurance of this.	R01	Training on why and how to attach additional contacts was provided by Central OIWCMS team in November 2024 as part of a day-long training offer to all of the Patient and Family Relations team on the use of the Feedback module.  Commence Quarterly Complaints Audit to provide assurance that training is being embedded in practice.	Jul-25	Not Met	Mar-26	Open	<a href="#">25/26 Q2 Update:</a> 250925 (AK) Proposed revised date of March 2026 due to staff sickness in the Putting Things Right Team.	
EA/2425-019	WRP	2024/25	QuEST	WRP Concerns Assessment 2024	Limited	Clare Appleton	Liam Williams	R02	R02	WAST to undertake further training in relation to capturing reopened complaints in Datix Cymru.	R02	Training from the OIWCMS team included a section on how to manage Reopened complaints.  Commence Quarterly Complaints Audit to provide assurance that training is being embedded in practice.	Jul-25	Not Met	Mar-26	Open	<a href="#">25/26 Q2 Update:</a> 250925 (AK) Proposed revised date of March 2026 due to staff sickness in the Putting Things Right Team.	

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