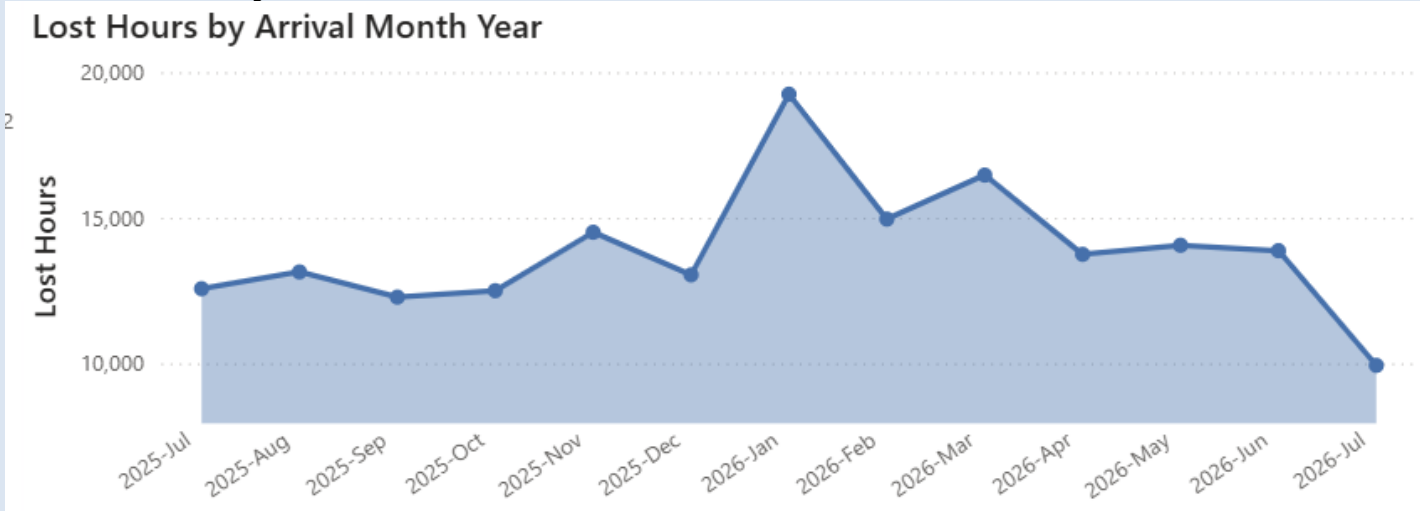


Bundle Reading Room 3 September 2026

8 Risk Management Report
Item 08 Annex 4 BAF

Risk ID 223	The Trust’s inability to reach patients in the community causing patient harm and death				Date of Review:		04/08/2026	TREND	OVERALL 25 (5x5)	
					Date of Next Review:		04/09/2026	➡		
IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		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										
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



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

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

Phase one and two of the Trust's Clinical Transformation Model - specifically the new performance framework - has now gone live, representing a key milestone in the delivery of an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. In parallel, early adoption of the 45 minute release 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.

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.

Risk ID 223	The Trust’s inability to reach patients in the community causing patient harm and death	Date of Review:	04/08/2026	TREND	OVERALL
		Date of Next Review:	04/09/2026	➡	25 (5x5)
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 45 Minute Release (45MR) from 1 October 2025 and 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. Plans to rollout H45 across a number of HB areas alongside a program of work to fine tune the clinical model. This will form the content of our Winter Plan. NHS P and I have been tasked by Welsh Government to oversee implementation of handover 45. In so doing, they have now conducted two meetings involving WAST and all six of the relevant health boards. Every health board has a plan for delivery of handover 45 for winter this year. From a WAST perspective, those actions will be incorporated into a single paper, this will be submitted to governance for oversight. Internally, WAST will be undertaking a series of oversight meetings to ensure that WAST continues to progress on actions that are within our control within those plans. Initially, those meetings are going to be chaired by Lee Brooks.					
12.05.2026 - The likelihood score has been increased due to sustained deterioration in handover lost hours over the last three months, with levels remaining well above what is absorbable within current rosters. Despite mitigating actions, the persistence of lost capacity means the Trust is increasingly unable to reach patients when needed, elevating the risk of harm. This scoring was approved at ELT on 27 th May 2026.					
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. NHS P&I Handover 45 Framework		NHS P and I have been tasked by Welsh Government to oversee implementation of handover 45			
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.2 (Updated August 2026 to include components and will be subject to continual governance), Resource Escalation Action Plan (REAP – v6.3 released December 2025), Clinical Safety Plan (CSP – released April 2026)		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 ETA Scripting, CCC Emergency Rule, Red call performance, Transfer of Care, ARA		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	Second Line of Assurance ETA dashboard, UHP reporting in local and business meetings. ODU dashboards, Performance Demand and Capacity performance metrics data, MIQPR (Monthly	Third Line of Assurance Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System Audit received June 25, actions being worked through.	

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(Swansea and YGC), EMS Demand and Capacity Review.	REAP levels and H45. Local Business Meetings performance discussions.	Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly).				
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. Ministerial Advisory Group (MAG)		5. 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				
6. NHS P&I and HBs compliance with H45 and beyond		6. While Health Boards have developed handover improvement plans, there is currently no routine, structured mechanism for independent review or validation of implementation, progress or effectiveness.				
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.				

Risk ID 223	The Trust’s inability to reach patients in the community causing patient harm and death			Date of Review:	04/08/2026	TREND	OVERALL 25 (5x5)
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Actions to reduce risk score or address gaps in controls and assurances		Action Owner (Internal only)	Completion / Milestone date	Progress Update			
1. 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.		Jonathan Edwards, Assistant Director of Operations, Coordination and Integrated Care	March 2027	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. May 26 – All the updates are managed through CMT project board June 2026 - The Clinical Model Transformation (CMT) Programme continues to progress, with a new steering group established to drive benefits realisation and a Call cat 3 workshop setting direction for the final year. Call cat 3 will commence in June 2026 and deliverables will form our winter plan approach. Key workstreams currently for CMT include; Digital Front-End, Remote Clinical Care, Urgent Community Response, and Emergency Response—have achieved significant milestones, though some areas remain dependent on workforce, partner, or system-wide changes. Evaluation with university partners is ongoing, focusing on data, executive agreement, and impact measurement. The programme is actively managing dependencies around data, digital input, funding, and capacity, with governance and risk review supporting structured delivery and sustainability planning			
2. Logistical arrangements for release to Respond		Sonia Thompson	October 2026	Clinical logistics team have worked up an approach including costs which have been shared with Welsh government – waiting confirmation from Welsh government on if they will take the costs. Work has been done on the protocol on release to respond approach. Awaiting Welsh Government to approve governance. 16.04.2026 - Following the NHS Leadership Board on 24 March, there was an ambition set by those present to implement R2R by 21 April. To activate the approach, WAST has determined that additional logistics such as vehicles and trolleys must be purchased. This requires funding and Welsh Government have confirmed that no funding will be released and NHS P&I should be approached. Executive DOO to discuss with NHSP&I on 2 April. WAST is preparing its approach but will be unable to implement without the release of funding.			
3. Handover 45		Lee Brooks, Executive Director of Operations	December 2026	May 2026 – Work continues with Health Board partners to support implementation of system actions intended to reduce handover delay and improve ambulance release. Meetings have commenced with AB, BCU and SBUHB to realise the actions required for H45 implementation by September 2026. June 2026 update – ABUHB, SBUHB and BCUHB have met with NHS P&I and are required to submit final plans by 12 June setting out trajectories to achieve 100% handover within 45 minutes. Work will then progress with Hywel Dda, Cardiff and Vale, and CTM on their submission plans, with a further NHS P&I meeting expected in mid to late July. July 2026 update – The final HBs have met, and all submitted their plans to NHS P and I. Work now will be established to monitor progress against the trajectories set through a series of internal scrutiny meetings supported by a story board. This will enable us to see how progress is tracking and be able to quantify any performance gains as a result.			

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust’s Ability to Provide a Safe & Effective Service for Patients			Date of Review:		03/08/2026		TREND		OVERALL 25 (5x5)				
				Date of Next Review:		03/09/2026		➡						
IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments		THEN 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		RESULTING IN 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							
Risk Commentary Discussions continue through Senior Leadership Team risk reviews to consider Risks 223 and 224 in conjunction, ensuring alignment of controls, assurances and system dependencies. This approach recognises the intrinsic relationship between ambulance handover delays and the Trust's ability to respond to patients in the community, with both risks continuing to be driven predominantly by external system pressures and variation in Health Board performance. This risk remains at the highest level. Whilst some Health Boards have demonstrated periods of improvement, performance remains variable across Wales and recent deterioration in handover lost hours has increased pressure on ambulance availability and timely access to definitive care. Prolonged handover delays continue to present a significant risk of patient deterioration, harm and poor experience, alongside 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 arrangements. 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, workforce capability and risk reduction. 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. Limited independent assurance on the implementation and effectiveness of Health Board handover improvement actions. Continued engagement with national and regional programmes, including Six Goals and Wait 45, remains essential to support improvement. NHS Performance and Improvement (NHS P&I) has reaffirmed its expectation that all Health Boards develop trajectories to achieve 100 per cent handovers within 45 minutes by winter 2026/27. During June 2026, Swansea Bay UHB, Aneurin Bevan UHB and Betsi Cadwaladr UHB were required to submit final delivery plans, with further work underway with Cardiff and Vale UHB, Cwm Taf Morgannwg UHB and Hywel Dda UHB. Whilst this represents an important strengthening of system accountability, recent deterioration in handover lost hours and variable compliance with 45 Minute Release standards continue to impact ambulance availability and system resilience. This risk is intrinsically linked to BAF Risk 223 relating to the Trust’s ability to reach patients in the community. The impact on staff wellbeing is recognised and managed through linked workforce risk 680.														
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) and associated 45 Minute Release expectations.					1. External Monitoring / Assurance Oversight through Welsh Government, including Six Goals and Joint Commissioning 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:	03/08/2026	TREND	OVERALL 25 (5x5)
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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.			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.			3. External assurance through NHS Wales performance oversight and escalation arrangements.			
4. NHS Wales Quality and Safety Framework and Duties of Quality and Candour External assurance through NHS Wales quality, safety and candour frameworks.			4. 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 including NHS Executive oversight and escalation processes, to manage periods of sustained operational pressure and deteriorating handover performance.			5. Assurance through national operational oversight, escalation Ministerial Advisory Group (MAG) review and system performance 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, Release to Respond (R2R) arrangements, Resource Escalation Action Plan (REAP) and Clinical Safety Plan (CSP) and Operational Delivery Unit (ODU) oversight arrangements. 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. Emerging system approaches, including Release to Respond (R2R), may provide additional mitigation; however implementation remains dependent on agreed operational models and funding arrangements. 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, patient safety 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 during prolonged waits to access definitive care 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.	

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust’s Ability to Provide a Safe & Effective Service for Patients	Date of Review:	03/08/2026	TREND	OVERALL 25 (5x5)
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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. These arrangements also support triangulation of confirmed harm, deterioration themes and exposure to harm associated with delayed handover, informing organisational learning, escalation and wider risk mitigation activity. 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, mortality review, patient safety reporting and triangulated harm intelligence reporting	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. 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.		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.	
Control 5: Clinical Model Transformation (CMT) Implementation of the Clinical Model Transformation (CMT) to improve clinical triage, early clinical intervention, decision-making and demand management. CMT provides an internal control to reduce avoidable conveyance, improve early clinical intervention and support more clinically informed prioritisation 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 remains a gap. Although NHS P&I has strengthened oversight through the requirement for Health Boards to develop trajectories and delivery plans for 100 per cent compliance with 45 Minute Release by winter 2026/27, these arrangements are not yet sufficiently mature to provide assurance of sustained system-wide improvement.			

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust’s Ability to Provide a Safe & Effective Service for Patients		Date of Review:	03/08/2026	TREND	OVERALL 25 (5x5)
			Date of Next Review:	03/09/2026	➡	
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. No update has been received on the national rollout yet. WAST & C&VUHB continue to utilise the pilot version.	
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 implementation ongoing	The Audit Wales review focused on the effectiveness of the wider urgent and emergency care system across Wales rather than individual services such as NHS 111 or the WAST website. Recommendations centred on strengthening whole-system accountability, improving patient flow and handover arrangements, enhancing the use of data and quality intelligence, and reinforcing governance, assurance and performance oversight. Audit received June 25, actions are being worked through. Completion date yet to be received.	

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:		04/08/2026		TREND	20 (4x5)
				Date of Next Review:		04/09/2026		➡	
IF the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared		THEN there is a RISK that the Trust’s Incident Response will be suboptimal	RESULTING IN avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability.		Likelihood	Consequence	Score		
				Inherent	5	5	25		
				Current	4	5	20		
				Target	2	3	6		
IMTP Deliverable Numbers:									
Strategic Objective: 1 Providing the right care or advice, in the right place, every time									
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. <i>This Board Assurance Framework (BAF) extract is supported by a more detailed appendix of itemised actions required to permit greater scrutiny of remaining gaps and actions, as well as a detailed repository of control measures that have been successfully implemented.</i>									
CONTROLS			ASSURANCES						
			Internal Management (1 st 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:	04/08/2026	TREND	20 (4x5)
			Date of Next Review:	04/09/2026	➡	
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. Prior to progressing the outstanding 18 recommendations, the organisation is awaiting a response from the JCC in relation to approval of funding.				
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:		
1. 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). May 26 – Annexe A has been updated with progress on this action.		

Risk ID 201a	Relationships with Stakeholders			Date of Review:		06/08/2026	TREND	16 (4x4)
				Date of Next Review:		06/09/2026	➡	
IF The organisation fails to engage key stakeholders (Welsh Government, Audit Wales, Internal Audit, HIW, Health Boards and Local Authorities, NHS P&I and JCC) in a meaningful and transparent way	THEN there will be a lack of stakeholder confidence in our ability to delivery our strategic objectives and system wide goals	RESULTING IN weakened strategic influence, impact on funding streams or escalation arrangements		Likelihood	Consequence	Score		
			Inherent					
			Current	4	4	16		
			Target	3	4	12		
Strategic Objective: Four - Developing services in collaboration								
EXECUTIVE OWNER		Director of Partnerships and Engagement		ASSURANCE COMMITTEE		Trust Board		
Risk Commentary The challenges of the financial position for 26/27 and the difficult choices that we are having to make as a result of that work represent a significant reputational risk. <i>There is clearly a greater focus by the new Government on performance which could represent a risk.</i> Effective stakeholder relationships are critical to the Trust’s ability to deliver its IMTP commitments and system-wide goals. It is particularly important that we consolidate relationships with Health Boards, JCC and NHS P&I, as well as new government and civil service and policy leads. The Trust operates within a complex system environment with financial pressures (linked to risk 139), transformation initiatives and performance scrutiny affecting stakeholder confidence. Failure to sustain proactive engagement and transparent reporting may result in increased oversight, constrained funding flexibility and diminished system influence along with reduced stakeholder engagement and support in transformation goals. This risk is linked to risk 100 and risk 139. Oversight of this risk will sit with the Trust Board rather than the People & Culture Committee as the scope of these risks extends beyond staff engagement.								
CONTROLS				ASSURANCES				
1. Web based resource for Politicians published				2. Consistency of available data and core documents				
2. Engagement on redevelopment of LTS – work with stakeholders.				3. Stakeholder mapping underway as of May 2026. Planning in place				
4. Strategic Engagement Framework in place				2. Focus on IMTP priorities that require stakeholder engagement (e.g. commercial partnerships, academic partnerships and LTS). The framework is being updated into a formal strategy.				
5. Balanced Financial Plan 2026/27				3. Financial monitoring reports				
6. Regular engagement meetings with Welsh Government and partners				4. Strategic engagement tracking				
7. Audit and regulatory engagement processes				5. HIW Reports (E) and third line of assurance on processes				
8. New Accountability and Operating Framework NHS Wales				6. NHS P&I reporting				
9. Board reporting and public transparency				7. Board reporting on engagement priorities. Welsh Government performance discussions, NHS Wales Joint Commissioning Committee reports (E)				
10. New engagement plan for new key stakeholders developed for ELT				8. Engagement approach implementation and executive level scrutiny				
11. Individual professional relationships built up over time				9. Continuity and trust over time				
GAPS IN CONTROLS				GAPS IN ASSURANCE				
1. Operational/Executive consistency of messaging				1. No consistent way of gathering information in consistent stakeholder engagement – this gap is unlikely to be easily closed.				
2. Reliance on individual relationships rather than formalised frameworks				2. This gap is unlikely to be easily closed as the continuity, and trust is lost if individuals move on				
3. Limited formal evaluation of stakeholder confidence levels				3. Difficult to evaluate as it will be variable over time and by stakeholder – unlikely to be easily closed as there isn’t a universal perspective – it is personal reputation versus organisational impact				
4. Financial savings may result in reputational risk				4. No gap in assurance as assurances are robust				
Actions to reduce risk score or address gaps in controls and assurances			Action Owner	By When	Progress Notes:			
1. Align engagement reporting to IMTP milestones and approved partnership reporting to Board			DoP&E	Routine BAU Quarterly reporting as per IMTP reporting	Reported through IMTP routes (commercial, academic partnerships) Political – partnership will be reported twice a year to Board in May and November			
2. Approach to management of stakeholders and creation of strategic opportunities for dialogue and discussion			DoP&E	End Q2 26/27	This action was discussed by the ELT in July 2026, and work is underway on engagement strategy further developing the existing framework.			
3. Managing political environment and any changes resulting from this			DoP&E	Routine BAU	Sharpened focus due to this being an election year. Written to FM and HM and also engagement via the NHS Confed.			

Risk ID 201b	Poor Patient Experience Affecting Organisational Reputation			Date of Review:		03/08/2026	TREND	16 (4x4)
				Date of Next Review:		03/11/2026		
IF A patient receives a poor experience from the Trust; the Trust receives negative regulatory reports or adverse media scrutiny		THEN There is a risk that public confidence in the organisation may decline and scrutiny from regulators and oversight bodies may intensify	RESULTING IN Reputational damage that undermines confidence in the Trust’s ability to deliver safe, high-quality care and achieve its strategic objectives		Likelihood	Consequence	Score	
				Inherent	4	4	16	
				Current	4	4	16	
				Target	2	4	8	
IMTP Deliverable Numbers:								
Strategic Objective:								
EXECUTIVE OWNER		Director of Nursing	ASSURANCE COMMITTEE		Trust Board			
Risk Commentary								
Following the introduction of measures to address this risk, patient feedback, compliments learning and patient stories are demonstrating sustained positive outcomes. These arrangements support the identification and sharing of good practice, strengthen clinical leadership and contribute to public confidence. Performance has remained consistently above the 85% benchmark. Patient experience is one of the key determinants of quality of the care provided by the organisation. The Trust continues to operate within a high-demand environment where system pressures, transformation initiatives and service redesign create variability in experience. The Trust is triangulating intelligence from various information sources across the organisation such as Freedom of Information, PECI, SCIFs and PTR complaints and concerns data to identify emerging themes. However, there remains risk exposure where learning is delayed or where operational performance impacts the patient journey. This risk is closely linked to risks 223 and 224, as effective control of those operational and performance risks will directly influence patient experience and reputational exposure. The expectation is that there will always be a relatively high residual risk which will be influenced by wider system pressures, such as delays in responding and handover delays. Despite robust training, continuous improvement process in the Trust there will be constraints such as staff sickness levels, variability in demand, external pressures including end to end care pathways particularly if there are no consistent pathways across Wales. Public perceptions may not always align with the Trust’s delivery model. Additionally, high profile reputational incidents will impact the ability to fully mitigate this risk.								
CONTROLS			ASSURANCES					
			Internal Management (1 st Line of Assurance)					
1. Corporate Governance oversight via QuEST and Board			1. Regular patient experience reporting to Committees and Board (minutes and papers)					
2. Listening to People framework, PTR arrangements and recovery trajectories.			2. Recovery trajectories and implementation of Listening to People monitored through relevant governance groups					
3. Education and training and organisational learning programmes focussed on supporting quality and safety, patient experience and statutory duties.			3. Workforce education compliance data					
4. Triangulation of data from FOI, PECI, SCIF, concerns and incidents to identify themes and opportunities for improvement.			4. Function of QMG and QuEST with representatives responsible for sharing with relevant areas.					
5. Learning from death, incidents, complaints and safety review processes			5. Active engagement in processes by Head of Patient Experience and Community Involvement					
6. Media management and communications protocols			6. Trust Policies and engagement procedures led by Director of Partnerships and Engagement					
7. Public reporting through MIQPR and Board papers			7. MIQPR Dashboard and Beacon Dashboard					
8. Patient and public experience stories are regularly reviewed through Trust governance arrangements to inform service improvement.			8. Patient Story Trucker which provides evidence based for learning , QI and Assurance					
GAPS IN CONTROLS			GAPS IN ASSURANCE					
1. Variability in how learning from complaints is embedded operationally			1. Limited analytics to identify emerging patient experience themes and trends					
2. Complexity arising from the transition to Listening to People, including the need to manage cases under both legacy and new statutory frameworks.			2. Lag in external reporting cycles reducing real-time assurance					
3. Limited real time patient experience dashboarding			3. Limited measures to assess the impact of improvement actions on patient experience.					
4. Workforce pressures impacting service consistency			4. Variable assurance maturity across directorates					

Risk ID 201b	Poor Patient Experience Affecting Organisational Reputation		Date of Review:	03/08/2026	TREND	16
			Date of Next Review:	03/11/2026	➡	(4x4)
5. Limited ability to mitigate patient experience risks arising from wider system pressures, including ambulance response and hospital handover delays. – see Risks 223/224		5. Variable application of patient experience considerations in service redesign and organisational change.				
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When	Progress Notes:		
1. Strengthen mechanisms for sharing real time patient experience data across the Trust to manage expectations, providing clear communication		Head of Patient Experience & Community Involvement	BAU operational work 30 September 2026	- Trust staff can view compliments sent in by members of the public on its 'Staff Compliments' page on Siren, promoting a one location for all compliments. Regular internal promotion to encourage colleagues to share their compliment cards and emails with the Peoples Experience Team so they can be accurately recorded. - We are using the Care Opinion platform as an additional tool to receive external, transparent feedback that is then mapped to internal data for a more holistic view of experiences. - We are utilising QR codes 'Listening to People' response/resolution letters, on Ambulance Care transport vehicles and in the back of several Emergency Ambulance vehicles to collect feedback immediately, ensuring experiences are fresh. 03/08/26 The Task and Finish Group will support a consistent WAST-wide approach to managing public feedback, strengthening reporting accuracy and identifying resulting themes.		
2. Thematic learning from concerns and compliments to be embedded across directorates and translated into operational Improvement.		Assistant Director of Operations and Support Heads of Service (QMG Link)	August 2026	- Compliments thematic learning is reported to QMG. Forms part of always on reporting. - Complaints discussion to be scheduled.		
3. Implementation of the Always On Reporting principles in line with the new listening to patients' statutory regulations and the mandatory peoples experience framework.		Assistant Director of Quality Governance	August 2026	Underway. Work to be done on wider quality elements.		
4. Implementation of multiple feedback channels to capture real time experience data to link to Civica enabling real time reporting.		Experience and Insights Manager	May 2026 Complete	- Progress in the roll out of SMS text messaging (for 999) callers along with supportive QR Codes in the backs of ambulance vehicles to capture experiences. Dashboards in development ready for June 2026. Real time experience surveys will be on EPCRs for feedback from crews. Public feedback channels are in place and promoted to the public, with consistent reporting across the multiple routes available. Control 8		
5. Targeted engagement work to continue through community engagement processes and patient story development to improve understanding of patient experience and inform service improvement.		Head of Patient Experience & Community Involvement	April 2026 commenced 30 September 2026	- Internal commissioning arrangements are in place with more effective targeted community engagement taking place. - Through the 'Listening to People' Framework the Peoples Experience Team and Listening to People team have been aligning their work to support listening discussions and triage cases where consideration to a person's needs may be better met through completing a patient story. The approach through patient storytelling from the Peoples Experience team is providing both a restorative intervention and a learning opportunity for the Trust. Linked to the PEGI OCP; the next stage is expected to commence on 1st September 2026. Once fully embedded in the commissioning model, this will become business as usual.		
6. Patient/Public experience stories are presented and discussed at Trust Board; QuEST (Quality Committee) and Quality Management Group, these stories are linked to reflect wider experience data recorded through various engagement channels.		Head of Patient Experience & Community Involvement	Ongoing BAU 30 September 2026	- Linking individual patient stories with wider experience data (i.e. surveys, complaints, and incident reports) involves integrating qualitative, emotional narratives with quantitative metrics to provide a comprehensive, actionable picture of healthcare quality. This process is using stories to explain the "why" behind trends and presenting a human-centric insight. - Tracker has been implemented as a directorate deliverable as part of an ongoing improvement to demonstrate how intelligence is utilised to improve, drive change and benefit patients and staff outcomes. 03/08/26 Work is progressing to increase the volume of stories from complaints and compliments, identify their source, and align with the national approach to storytelling. This is linked to Action 5.		

Risk ID 671	Unauthorised or Inappropriate use of AI technologies		Date of Review:	27/07/2026		TREND	16 (4x4)
			Date of Next Review:	27/08/2026		➡	
IF 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 critical-thinking or governance	THEN 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 accuracy, transparency, medical device, equality, Welsh Language and ethical requirements	RESULTING IN 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 or poor quality/accuracy outputs, 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: 3 - Being at the forefront of innovation and technology							
EXECUTIVE OWNER		Director of Digital	ASSURANCE COMMITTEE	Finance & Performance Committee			
Risk Commentary The current risk remains at a score of 16 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. Additionally, there is not yet an organisational policy, nor strategic steer to support staff in using AI for professional purposes, although the AI Policy is in development. Following a discussion at the June meeting of the AI Steering Group regarding “skill atrophy”, the risk description here has been updated to acknowledge the related “inappropriate usage” risk whereby over-reliance on AI tools, or inadequate application of critical-thinking or human judgement to AI outputs, can result in possible inaccurate, unethical, biased or poor quality information being used for decision making within the Trust. As AI becomes more widely utilised across the Trust, this risk of inappropriate use also includes the possibility of greater volume of outputs at a faster pace, impacting and linked to other Directorate and Corporate risks such as Risk ID 680 (organisational culture and employee experience). 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.							
CONTROLS			ASSURANCES				
1. Guidance & Awareness a) Gen-AI guidance + Engagement sessions (small audience) b) Procurement toolkit c) Guidance for using Copilot for AAA reports (published via Siren) d) Guidance and training for Copilot Chat (led by DHCW Centre of Excellence) advertised internally			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. c) Guidance reviewed by AI Steering Group April and May 2026 d) Comms via Siren April 2026 with FAQs about Copilot Chat campaign; informal confirmation that WAST members are attending DHCW / Microsoft delivered training sessions				
2. Strategic Alignment a) IMTP reference to a Digitally-led “Responsible AI” workstream for 2026/27 and specific use cases b) Governance route via IGSG – a sub-group of ELT			2. Strategic Alignment a) AI safety and adoption updates reported via Digital Report to Finance & Performance Committee 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 c) Approved usage of Copilot Chat across NHS Wales			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 c) Monitoring of Copilot usage by WAST users as part of DHCW rollout campaign				
4. Processes a) Cyber Assurance of suppliers during procurement processes through existing mechanisms e.g. cyber essentials			4. Processes a) Cyber risks and Data Protection logs reported to IGSG, plus specific assessment of cyber risk from recent AI model releases and recommendations for WAST included in cyber reporting to Finance & Performance Committee (May-26)				

Risk ID 671	Unauthorised or Inappropriate use of AI technologies	Date of Review:	27/07/2026	TREND	16 (4x4)
		Date of Next Review:	27/08/2026	➡	
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 d) Decision making and ethical governing mechanism implemented in AISG to ensure consideration of bias fairness, transparency, security and other principles of Responsible AI during meeting discussions. e) (Interim) AI / Agent request form		b) Monitoring of Datix incidents related to data breaches and security c) - d) Responsible AI governance mechanism utilised by AISG regularly, and shared with IGSG for visibility and assurance e) An interim AI / Agent request form drafted, and tested with a first Copilot Agent use case, aligned to the principles of Responsible AI and the interim governance mechanism There has been no impact on the score to date; however, once implemented more widely beyond the Steering Group and applied to new AI use cases and tooling decisions, an impact is expected.			
5. Expertise a) Ability to draw on Digital expertise for advice (including data science, algorithmic, cyber, data protection, data quality and other relevant domains) 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		5. Expertise a) AI risks and issues managed by AISG, reporting via IGSG ; Digital Oversight Group (DOG) to support with advice and prioritisation of new requests from late July 2026 b) Demo of developing AI module from a supplier of one of WAST’s critical systems, to cross-Directorate group, for early understanding of opportunity, capabilities and risks (July-26) c) First meeting of monthly AISG occurred in October 2025, with reporting via AAA to IGSG monthly ongoing. First AI Agent use case reviewed by AISG in July 2026 with advice and expert support offered for next steps. The steering group was included in the original scoring assessment when the risk was first articulated, so any impact on the score has already been accounted for.			
GAPS IN CONTROLS		GAPS IN ASSURANCE			
1. Guidance & Awareness a) Copilot rollout and chat requires guidance for all WAST staff (e-learning module in development) b) General awareness sessions / e-learning for all WAST staff c) Ethics and responsible AI frameworks d) Strategic approach to skill atrophy and skills framework (e.g. which tasks the Trust determines can / cannot be augmented with AI) e) AI for minute taking guidance		1. Guidance & Awareness a) eLearning uptake; testing of the e-learning module by the AISG in June 2026. 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 d) Clear set of tasks which are human-only suitable, and a set of tasks / skills which can be augmented with AI, supported by e-learning / awareness of unintentional skill atrophy e) Dissemination of AI for minute-taking guidance to cohort of WAST staff most likely to be responsible for meeting group / committee secretariat support, and AAA reports.			
2. Strategic Alignment a) AI Mission Statement / strategy b) Clear set of ‘approved’ use cases c)		2. Strategic Alignment a) Regular reporting and clear governance route from AI Steering Group to Board b) AI Use Case log with regular review cycle and clear reference points – AI Steering Group to maintain alignment of use cases and horizon scan (for opportunity and risk)			
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 projects 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			

Risk ID 671	Unauthorised or Inappropriate use of AI technologies	Date of Review:		27/07/2026	TREND	16 (4x4)
		Date of Next Review:		27/08/2026	➡	
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 June 2026 December 2026	AI Policy in development with support from TU Partner; due to recent absences of key individuals and capacity challenges in Digital, in agreement with Policy Group, this has been further deferred until November 2026 meeting to allow inclusion of recent guidance and external policy updates. Aim for publication by December 2026.		
2. Agreement on sanctioned and unsanctioned apps, and block of certain apps / sites		James Rowland	Q4 25/26 Q2 26/27	WAST to align with national steer on sanctioned / unsanctioned apps. This is being managed as business as usual but awaiting response from DHCW regarding DPIA around the existing sanctioned tooling of Copilot and Copilot Chat.		
3. Awareness campaign (including ethics, DP, shadow IT risks)		Leanne Smith	Q1 26/27 Q3 26/27	To be managed by AISG – this will need to feature later in the AISG workplan to be conducted after development of the ethics and responsible AI framework, however, will also be partially covered by the e-learning module of action 7.		
4. Board Development Day and AI Mission Statement development with Trust Board		Leanne Smith	February 2026 June 2026 Autumn 2026	Deferred from June 2026 to autumn 2026 Board Development Day due to recent absences of key individuals in Digital, and a scheduling conflict with the February BDD – the June session will cover Board Digital Maturity more broadly, but will likely feature AI and related emerging tech. A strategic steer from ELT for AI specifically may still be required after the Board Development day.		
5. Alignment with WG and NHS Wales AI policy positions		Leanne Smith	Q4 25/26 Q3 26/27	Proactively engage with WG AI Commission March-26: NHS Wales AI commission is being redesigned. Engagement has not been able to progress.		
6. eLearning for all staff		Leanne Smith	Q4 25/26 Q3 26/27	Jun-26: AISG reviewed the module in development and provided feedback for this to be iterated. One section regarding organisational governance and responsibility is awaiting strategic discussion to help steer and will need to align with the AI Policy.		
7. Broader AI Governance Framework to be developed (including reference to IG x AI programme confirming DPIA and checklists are appropriate), procurement framework, Cyber assurances, and Clinical Safety processes.		Leanne Smith	Q4 25/26 2026/27	It has been confirmed that this will be a requirement of the 26/27 IG Toolkit and so progress will occur throughout 26/27 as part of the regular Toolkit work led by the IG team. It will need to be completed by March 2027. July-26: two new AI related risks have been added to the IG Risks & Issues log related to shadow AI, and AI technology being built into existing supplier systems		
8. WG AI Commission membership / alignment		Leanne Smith	Q3 25/26 Q2 26/27	Jun-26: it is believed a different forum will be established under DDaT governance structures for NHS Wales. This action is unlikely to be achieved as is described. Suggest close / reframe this action once confirmed where AI responsibility features in all Wales governance structures.		
9. Document sensitivity / confidentiality tagging project (linked to SharePoint migration project)		Leanne Smith / Aled Williams	Q4 26/27	Large scale project across digital – this has not been planned into the 26/27 IMTP due to financial constraints but may feature in future years of the plan. In the meantime, the need for All-Wales implementation of appropriate sensitivity labelling is being escalated through the NHS Wales IGMAG (Information Governance) group.		
10. AI Lead to be identified and agreed		Leanne Smith	Q3 25/26 Dec-26	AISG to have oversight given no dedicated capacity nor roles in WAST. The AI Policy in development will detail responsibilities of all staff by group.		
11. Responsible AI framework to be cross-checked with existing Impact Assessments (e.g. EQIA, cyber and Data Protection) to inform a decision on whether specific AI impact assessments will be required		Leanne Smith	Q3 26/27	This will be progressed as part of the AI Policy development and consider whether the current EQIA can be applied to AI use cases or needs to be supplemented with AI specific considerations.		

Risk ID 680	Failure to prioritise people capability and organisational culture could result in deteriorating Employee Experience, reduced wellbeing and absence			Date of Review:	27/07/26	TREND	16 (4x4)		
				Date of Next Review:	27/08/26	➡			
IF insufficient focus on people capability and organisational culture		THEN will lead to a poor employee experience, low morale, burnout, fatigue, reduced wellbeing and increased sickness absence		RESULTING IN Adversely impacted workforce capacity, patient safety and the Trust’s ability to deliver safe and effective ambulance services.			Likelihood	Consequence	Score
						Inherent			
						Current	4	4	16
						Target	3	4	12
Strategic Objective: 2 – Enabling our people to be the best that they can be									
EXECUTIVE OWNER:		Director of People		ASSURANCE COMMITTEE:		People & Culture Committee			
Risk Commentary									
Failure to maintain a positive organisational culture, sustainable workforce capacity and effective leadership behaviours may compromise the Trust's ability to reduce this risk, affecting workforce sustainability, employee experience and the delivery of safe and effective services.									
The risk remains above tolerance due to ongoing workforce, cultural and organisational pressures and significant change and transformation that continue to impact employee wellbeing, engagement, attendance and retention. These factors challenge the Trust's ability to develop and sustain a resilient workforce capable of meeting current and future service requirements. Strategic controls are in place to strengthen leadership, improve workforce experience and support organisational culture. Whilst these controls provide assurance that the risk is being actively managed, their impact is not yet consistently realised across all areas of the organisation and therefore the current risk score remains unchanged. Further implementation and embedding of these controls are expected to reduce the likelihood and impact of the risk over time.									
CONTROLS			ASSURANCES						
MONITOR			Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.						
CULTURE									
1. Improving Wellbeing			Sustain a focus on improving the wellbeing of staff through implementing the Health and Wellbeing Plan.						
2. Staff Survey programme of work			Increased response rates; greater organisational focus on the survey and using the feedback effectively; demonstrable connections between staff feedback and actions taken.						
			Completed actions: - Update 09/03/26: 2025 data analysis commenced, high level summary presented to ELT in early March. - Update 19/06/26: Publish organisational results for 2025 survey						
CAPACITY									
1. Attracting and Retaining a Diverse Workforce			Develop and implement a recruitment and attraction plan that supports all roles in the organisation, including targeted recruitment plans that assures workforce diversity and equity targets are progressing.						
2. Managing Attendance			Continue the Managing Attendance programme to ensure staff attendance is effectively managed. Sickness absence data, trend analysis, and effectiveness reviews of the Managing Attendance programme provide assurance that attendance is being actively monitored and managed, with clear improvement trajectories.						
			Completed actions: - Continued monitoring and review of both long-term and short-term sickness absence through monthly meetings, ensuring effective tracking of absence levels and the provision of appropriate support to staff. - Maintained the delivery of Management of Attendance at Work (MAAW) training through bi-monthly scheduled sessions, with additional training provided where needs were identified						
CAPABILITY									
1. Our Change Management Approach			Change Management Workstream established as an enabling workstream within the CMT Programme, growing recognition of the importance of the people aspects of change.						
			Completed actions: Update 09/03/26: 2 x accredited Change Management courses scheduled for March, training a further 24 colleagues.						
2. Our WAST Way			Embedding compassionate leadership behaviours, Essential Conversations, routine Check-ins, and Crucial Conversations as core expectations of everyday leadership practice. Strengthening leaders’ capability to identify early signs of pressure, conflict, burnout or workload concerns through high-quality conversations.						

Risk ID 680	Failure to prioritise people capability and organisational culture could result in deteriorating Employee Experience, reduced wellbeing and absence		Date of Review:	27/07/26	TREND	16
			Date of Next Review:	27/08/26		(4x4)
		Completed actions: Update 19/06/26: Engagement & Prioritisation with Phase 2 Design				
GAPS IN CONTROLS		GAPS IN ASSURANCE				
CULTURE						
Improving Wellbeing		We continue to implement initiatives within the Health and Wellbeing Plan, with a particular emphasis on strengthening our approach to absence management, predominantly Stress Management, that will support managers to identify early signs of stress and take proactive steps to prevent issues escalating, ensuring colleagues receive timely and effective support.				
Staff Survey programme of work		Although we have seen a signification improvement in the NHS Staff Survey (42.1% in 2025 / 35.2% in 2024 / 23.2% in 2023) further participation is required.				
CAPACITY						
Recruitment and Attraction Interventions not fully embedded		While recruitment plans exist: - Targeted approaches (e.g., outreach, allyship-driven recruitment) are not consistently adopted. - Hiring managers vary in skill and confidence to recruit inclusively. - Recruitment supporting materials (toolkits, guidance) are not fully embedded across the organisation.				
Lack of proactive controls to address Attendance Variation		Managing Attendance remains a key programme, but: - Early warning indicators of deteriorating attendance are inconsistently recognised at local level. - Variation in the quality of return-to-work discussions and support plans. - Limited capacity to address system-wide causes of sickness (workload, fatigue, environment).				
CAPABILITY						
Limited consistency in Change Management Capability		Although the CMT Change Management Workstream is established: - Capability across the organisation is variable, especially among frontline and middle-tier leaders. - Change fatigue in some services limits effective adoption of new behaviours or processes.				
Variable Leadership Capability to embed Our WAST Way		Despite the leadership development work: - Not all leaders have sufficient capability to embed compassion-based behaviours confidently and consistently. - Supervisors and team leaders, in particular, may lack time or training to apply these behaviours. - There is no fully embedded mechanism to evaluate leadership behaviour maturity at scale.				
Actions to reduce risk score or address gaps in controls and assurances		Action Owner (Internal only)	Completion / Milestone date		Progress Update	
CULTURE						
Improving Wellbeing 1. Implement a Stress Management Policy supported by practical tools and resources to help colleagues and managers to identify early signs of stress and maintain sustained wellbeing.		Occupational Health Manager and Head of Workplace Wellbeing	Stress Management - Digital Risk Assessment developed by end Q2 2026/27 - Policy approved by end Q3 2026/27 - Launch of Digital Risk Assessment and Policy by end of Q3 2026/27		- Update 19/06/26: No further updates, work progressing as planned and will be delivered within the given timeframes. - Update 14/07/26: No significant changes since the last update. Work continues to progress as planned and remains on track to be delivered within the agreed timeframes. The policy is scheduled for consideration at the September Policy Group, with no anticipated impact on the timeline. In parallel, the Wellbeing Team is developing supporting workshop and training materials to complement the launch of the policy, including stress awareness sessions to aid implementation and staff engagement.	
Staff Survey programme of work 1. Increase engagement and response rates through targeted interventions, ensuring all		Head of Change & Insights	- Preparations and running of 2026 survey by end of Q3 2026/27 - Analyse 2026 results by end of Q4 2026/27			

Risk ID 680	Failure to prioritise people capability and organisational culture could result in deteriorating Employee Experience, reduced wellbeing and absence			Date of Review:	27/07/26	TREND	16
				Date of Next Review:	27/08/26		(4x4)
colleague voices are heard, and effectively use data to drive informed decisions and actionable insights				- Update 19/06/26: Directorate level data has been shared across the organisation and meetings with Directorate leads are underway. Refresh of communications and engagement plan for 2026 survey are underway. - Update 14/07/26: Directorate-level data has been shared and discussions with Directorate leads continue. The 2026 Staff Survey communications and engagement plan is being refreshed, and preparations for the new pulse survey platform are in their final stages, with go-live expected by the end of July.			
CAPACITY							
Recruitment and Attraction Interventions Not Fully Embedded 1. Recruitment Strategy: Design and implementation of an inclusive Recruitment Strategy that attracts, engages, and retains diverse top talent aligned with our organisational values and workforce needs.		Head of Strategic Workforce Planning, Recruitment & Systems	- Stakeholder Engagement by end of Q2 2026/27 - First Draft Document by end of Q3 2026/27 - Approval & Publication by end of Q4 2026/27	- Update 19/06/26: Continuing with stakeholder engagement, due to end in July 2026. Work has commended on the First Draft Document based on stakeholder engagement feedback. - Update 20/07/26: Stakeholder engagement is ongoing, with additional support from Strategy, Planning and Performance team helping to maintain progress and inform development of the first draft document. Although unforeseen activity relating to NQP recruitment has slightly delayed completion beyond the original July target.			
CAPABILITY							
Limited Consistency in Change Management Capability 1. Enhance managers’ ability to lead and navigate change confidently, reinforcing cultural transformation and organisational resilience		Head of Change and People Insights	- Further develop change management toolkit by end of Q4 2026/27 - Enhance connections between change management and OWW toolkit by end of Q4 2026/27 - Develop and implement development plan for Change Community, supported by robust comms and engagement plan toolkit by end of Q4 2026/27	- Update 19/06/26: Work is underway to further develop the change management toolkit, informed by feedback highlighting the need to strengthen involvement and engagement; practical tools have been created and are currently being tested with the Change Community. - Update 14/07/26: No further changes since the June update. Work to develop the change management toolkit remains underway, informed by feedback on strengthening involvement and engagement. The practical tools previously developed continue to be tested with the Change Community, with no significant developments or changes to report at this stage.			
Variable Leadership Capability to Embed Our WAST Way 1. Embed Our WAST Way Leadership Behaviours and Development Framework (inc. Managers Essentials) and progress the next phase to strengthen leadership and effective management.		Head of Culture & OD	- Pilot Priority Elements for Phase 2 Delivery by end of Q2 2026/27 - Expand Pilots & Ongoing Evaluation of Phase 2 by end of Q3 2026/27 - Embed Our WAST Way into Recruitment by end of Q4 2026/27 - Review, Celebrate & Plan Next Steps (Phase 3) by end of Q4 2026/27	- Update 19/06/26: Pilot Priority elements for phase 2 to commence in quarter 2. - Update 13/07/26: Development of the wider leadership pathway, including first-line leader development is progressing, alongside preparations for the September Leadership Connect conference focusing on civility, culture and patient outcomes			

Risk ID 690	SAR and Disclosure of Records Compliance			Date of Review:		27/07/2026	TREND	16 (4x4)
				Date of Next Review:		27/08/2026	➡	
IF records requests from patients, the public or staff are not processed consistently, correctly or in a timely manner		THEN inappropriate withholding of information or disclosures may occur, and statutory timeframes may not be met	RESULTING IN non-compliance with UK GDPR requirements, possible financial penalty, data breaches, and complaints causing negative patient or staff impact and reputational damage		Likelihood	Consequence	Score	
				Inherent	4	4	16	
				Current	4	4	16	
				Target	2	4	8	
IMTP Deliverable Numbers:								
Strategic Objective: 3 Being at the forefront of innovation and technology								
EXECUTIVE OWNER		Director of Digital Services	ASSURANCE COMMITTEE		Finance and Performance Committee			
Risk Commentary Previously , safeguarding information disclosed within a SAR response has resulted in a claim of £9,311 and submission of a Learning from Events Report to Welsh Risk Pool, with scrutiny of evidence of improvements. A subsequent compliance review of the Records Services procedures identified gaps and risk areas, and complaints indicate ongoing concerns about records access, handling and timeliness. There is also an element of risk relating to records services governance arrangements, which may not provide sufficient visibility potentially impacting compliance and assurance activities. Actions are detailed in the Records Recovery Improvement Plan, including SOP gaps and QA/approval routes requiring completion and monitoring. The consequence of breaching regarding the content of a disclosure will always be significant in terms of patient safety, quality, and compliance with regulation and legislation; however, with the proposed actions and mitigations, it is believed the likelihood of such a breach occurring would be low, and less likely to occur for a non-complex case. The Records Services team, supported by a short-term but concentrated “Records Recovery Taskforce” (responsible to the Information Governance Steering Group, IGSG) continues efforts to improve the position of the SARs backlog, processes & operations, and the resilience and wellbeing of the team. July-26: the IGSG commissioned the extension of the Records Recovery Taskforce for a further 8-weeks, into August 2026, to support the continuation of many of the identified and prioritised improvement activities. Whilst some process, automation and compliance related actions are progressing, the sustained pressure and high-volume of demand on the Records team means capacity and wellbeing remain a risk. The current insufficient resource levels could present a compliance risk in relation to: delivery of Subject Access Requests (SARs) and data disclosures to statutory timelines, which may expose the organisation to regulatory action accuracy and quality of responses, which increases the likelihood of data protection incidents and associated risk to individuals It should also be noted that there is a key absence in the Records team currently, and a vacant Records Officer post. As there is more to do to complete the objectives, mitigate remaining risk (and handle issues of complaints regarding delays and inappropriate disclosures), and manage capacity and resourcing risks , the risk is proposed to maintain the current score .								
CONTROLS			ASSURANCES					
			Internal Management (1 st Line of Assurance)					
1. Current team guides outline the processes for handling requests.			1. Fortnightly meeting with IG and RM to review any new regulations and reinforce existing requirements that may need reminders or clarification. Cross function “stand-up” meeting (3 x weekly) in place to support day-to-day handling of requests, provide visibility and support compliant disclosure.					
2. Weekly training sessions a delivered locally and in conjunction with the Data Protection Officer and IG team .			2. Recorded via a formal training log for each Records Officer					
3. Regular review of any new regulations and reinforce existing requirements that may need reminders or clarification.			3. Regular meeting series (fortnightly) between IG and RM, led by the Data Protection Officer (DPO).					
4. Development time allocated for mandatory training (to include Data protection, statutory response requirements.			4.					
5. Support and guidance offered to individual Records Officers, with monitoring of progress against individual cases.			5. Case tracker monitoring by Head of Records; with regular meeting series in place with individual Records Offices to conduct case reviews in detail, check compliance against process, and support unblocking next steps with more complex cases.					
6. Quality Assurance Checklist			6. DPO approved QA checklist in place, being utilised by the team					
7. Subject Access Request (SAR) SOP approved by DPO (including current legislation) and in place.			7. Feedback session with team conducted to ensure understanding and confidence in using the new SAR SOP.					
8. Access to Health Records (AHR) decision tree developed by DPO in place.			8. In use by the Records team, being verified by the IG team as part of a 2-week QA process.					
9. Refreshed suite of standard template letters for responses, DPO approved			9. Old template letters archived, team instructed to utilise new templates only; version control managed by IG team					

Risk ID 690	SAR and Disclosure of Records Compliance			Date of Review:	27/07/2026	TREND	16 (4x4)
				Date of Next Review:	27/08/2026	➡	
10. Risk-based prioritisation of incoming Records Requests				10. Trialling of new risk-based prioritisation, with shared responsibility for this prioritisation action rotating round Records Officers			
GAPS IN CONTROLS				GAPS IN ASSURANCE			
1. DPO approved SOPs or decision support aids for other Records Request types (e.g. police, coroner, and other internal and external requests) required				1. Current review of all request types with examples is in process which will clearly explain statutory requirements.			
2. Quality Assurance processes				2. Capacity to conduct QA for non-standard cases is extremely limited and often results in large backlogs sat with a single individual.			
3. Managing workloads to avoid deadline breaches.				3. Evidence of individual and team level training; and rotating operating model to handle pre-processing activities such as acknowledgements, categorisation, and prioritisation .			
4. Better tracking systems – manual tracking for the current increased workload is proving more difficult.				4. Current spreadsheet tracker requires review or improvement, or migration to a more robust digital system.			
5. Inadequate training/knowledge in correct processing requirements.				5. Targeted training sessions required.			
6. Increased capacity / resources within team to manage increased demand				6. Time logging of effort for different request types to support planning and future workforce requirements			
7. Oversight & assurance from DPO of disclosures and records processing				7. DPO assurance of compliance and timeliness received by IGSG; further visibility of performance reporting required (e.g. volumes, timeliness, % breaching)			
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:			
1. Complete and approve outstanding Records SOPs (including SAR quality assurance, application of exemptions, and legal basis for disclosure to third parties), with IG/DPO engagement; publish on SharePoint.		Head of Records (with DPO oversight)	March 2026 June 2026 July 2026	May-26: Subject Access Request (SAR) SOP complete, with DPO approval. In place and being utilised daily by the team. Access to Health Records (AHR) decision tree in place to support until full SOP complete. July-26: SOP for Police Requests is outstanding and being addressed as part of the Records Recovery Taskforce which will continue past the original 8-week period to support with the remaining actions including review of other (non-SAR/AHR) request types.			
2. Implement formal dual Quality Assurance (QA) /review process where needed (e.g., IG team, Safeguarding Team, Legal Services Team), particularly for safeguarding content, serious harm exemptions (clinician review), and complex exemptions such as ‘functions to protect the public’ or ‘legal professional privilege’.		Head of Records (with DPO oversight)	March 2026 June 2026 Sept-26	May-26: QA checklist developed and in place; standard QA occurs between Records Officers, however, for non-standard or more complex requests, QA must be conducted by a senior member of the team. Due to current absences, this is with a single member of the team, creating resilience risk. Further improvement required, which is being addressed as part of the Records Recovery Taskforce. Jun-26: QA processes are being formally reviewed by the Information Governance team. Any lessons learned or suggestions to strengthen this process will be provided back to the Records team at the end of June.			
3. Deliver targeted training/briefings on SAR and appropriate data disclosure processes.		Head of Records (with DPO oversight)	March 2026 June 2026 Sept-26	May-26: Training sessions delivered by Data Protection Compliance Managers and Data Protection Officer to the Records Team. Feedback session held to also check understanding and confidence of the SOP and clarify any points of uncertainty. At the end of the Records Recovery Taskforce, a survey will be conducted with the team to understand any areas of training that is outstanding or additional support required.			
4. Establish an audit schedule (quarterly sampling of Records outputs) with findings reported to IGSG.		Head of Records (with DPO oversight)	March 2026 July 2026	May-26: this is an action noted on the Records Recovery Taskforce delivery plan, however, is not prioritised for the 8-week period, and will be an action that exists beyond the closure of the Taskforce, to be picked up as part of the ongoing improvement actions.			
5. Maintain TU feedback loop: continue engagement, feedback, and resolution of concerns.		Head of Records (with DPO oversight)	March 2026 June 2026 Sept-26	May-26: a formal report, sharing progress from the Records Recovery Taskforce, was delivered to the May meeting of the Information Governance Steering Group (IGSG). In June, the IGSG will receive a closure report from the Taskforce, detailing actions complete, improvement, and reduction in risk, along with outstanding actions which will need to continue into Q2.			
6. Sufficient capacity & resourcing to deal with requests		Assistant Director of Digital	Sept-26	Given sustained high volume of demand, a key absence, and a vacant post, the function is currently exploring all options to provide additional resource or capacity into the Records team. This may include support from colleagues on alternative duties across the Trust; agency or external outsourced specialist support for redaction or SAR processing; accelerating permanent recruitment of vacancies, and other options (such as clarifying and reducing scope of the function).			
7. DPO assurance		Assistant Director of Digital	Sept-26	Oversight currently through regular DPO x Records meetings, direct contact with the Records team and its members, approval of specific request types (e.g. CCTV) which are included in SOPs, and as a member of stand-up meetings (3xweekly). Further actions to support oversight and assurance to be determined. Performance monitoring being addressed, with data validation underway, and draft dashboard developed to provide visibility to Records team. DPO, IDS leadership and IGSG of progress against the backlog and incoming requests.			

Risk ID 700	Failure to implement and deliver the statutory requirements of the revised Concerns Regulations and accompanying ‘Listening to People’ Guidance.			Date of Review:	14/08/2026	TREND	16 (4x4)	
				Date of Next Review:	14/09/2026	➡		
IF The Trust is unable to sustainably reduce and manage the current concerns backlog whilst implementing and meeting the statutory requirements of the revised Concerns Regulations and associated Listening to People Guidance,	THEN The Trust is unable to meet its statutory and regulatory obligations or demonstrate effective quality governance, organisational learning and improvement,	RESULTING IN Regulatory escalation, increased external scrutiny, reputational and financial impacts, reduced confidence among patients, staff, partners and regulators, poorer patient and staff experience, and missed opportunities to learn and improve.	Inherent					
			Current		4	4	16	
			Target		3	3	9	
Strategic Objective:								
EXECUTIVE OWNER		Chief Clinical Officer	ASSURANCE COMMITTEE		Quality, Safety and Patient Experience Committee			
Risk Commentary								
The revision of the Concerns Regulations in statute in 2025 and implementation of revised statutory guidance ‘Listening to People’ on 1 April 2026, represents a significant change to the statutory framework governing concerns management, organisational learning and quality governance across NHS Wales. The revised Regulations place new requirements on NHS organisations to meaningfully engage with people who raise concerns, make better efforts to resolve concerns in a timelier and more person-centred way, support people to access increased Redress settlements where appropriate and demonstrate effective learning and improvement. As a national provider operating across multiple healthcare settings and organisational interfaces, the Trust is managing increasing complexity and demand across concerns management, aligned clinical quality governance processes and organisational learning functions. These pressures are occurring alongside wider organisational transformation, workforce constraints and financial pressures, within a national environment where guidance, assurance arrangements and regulatory expectations continue to evolve. In response, the Trust has established a Concerns Management Improvement Programme, supported by dedicated workstreams and oversight through the Strategic Transformation Board and established quality governance arrangements. This programme is focused on embedding the statutory requirements of Listening to People, strengthening quality governance and organisational learning arrangements, and developing a sustainable future operating model for concerns management. The Trust is also moving towards a more integrated approach to quality governance and organisational learning, bringing together intelligence from concerns, incidents, claims, coronial activity, patient experience and other quality systems to identify themes, demonstrate improvement and provide assurance. This approach supports the wider development of the Trust’s Quality Management System and aims to ensure that learning is translated into measurable improvements in patient care, experience and outcomes. Whilst progress has been made, risks remain relating to workforce capacity, digital maturity, data and performance reporting, integration of quality intelligence, and the ability to demonstrate sustainable compliance and assurance over time. Failure to do so may reduce confidence amongst patients, staff, partners, regulators and the public, and limit the Trust's ability to demonstrate effective quality governance and organisational learning. This risk is intrinsically linked to the Trust’s wider Quality Management System ambitions, financial sustainability and organisational transformation agenda.								
CONTROLS			ASSURANCES					
MITIGATE - Internal <i>How do we know the controls are effective. How will these impact the target risk score?</i>			Internal <i>over the three lines of assurance. How do we know the assurances are effective</i> <i>Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk</i>					
Control 1 –Concerns Management Improvement Programme: The Trust has established a Concerns Management Improvement Programme, supported by dedicated workstreams, to implement the statutory requirements of the Listening to People Guidance,			First Line of Assurance The Concerns Management Improvement Programme Board oversees delivery of the programme through regular review of milestones, risks, dependencies,		Second Line of Assurance The Strategic Transformation Board and established Quality Governance arrangements provide oversight and challenge to the Concerns Management Improvement Programme, reviewing progress against milestones, risks, dependencies and		Third Line of Assurance The Quality, Safety and Patient Experience Committee (QuEST) receives regular reports on the Concerns Management Improvement Programme, providing independent scrutiny and assurance to the Board	

Risk ID 700	Failure to implement and deliver the statutory requirements of the revised Concerns Regulations and accompanying ‘Listening to People’ Guidance.		Date of Review:	14/08/2026	TREND	16 (4x4)
			Date of Next Review:	14/09/2026		
strengthen quality governance and organisational learning arrangements, and develop a sustainable future operating model for concerns management.		performance measures and workstream progress, providing operational assurance that the statutory requirements of the Listening to People framework are being implemented and sustained.	emerging issues. This provides assurance that the Trust is progressing towards sustainable compliance with the Listening to People framework and is aligned to the Trust's wider Quality Management System, organisational learning arrangements and statutory obligations.		regarding progress towards sustainable compliance with the Listening to People framework and the effectiveness of the Trust's quality governance and organisational learning arrangements. The Deputy Director of QPTR attends the National Strategic Oversight Group	
Control 2 –Statutory Compliance Framework The Trust has established policies, procedures, governance arrangements and operating processes aligned to the Concerns Regulations and associated statutory requirements to support concerns management, organisational learning and quality governance.		First Line of Assurance Compliance with policies, procedures and statutory requirements is monitored through routine case review, performance monitoring and operational oversight.	Second Line of Assurance Established Quality Governance arrangements provide oversight and challenge regarding compliance with the Listening to People framework, reviewing policies, processes, performance and emerging risks to provide assurance that statutory requirements are being met.		Third Line of Assurance The Quality, Safety and Patient Experience Committee (QuEST) receives regular reports on statutory compliance, quality governance and organisational learning, providing independent scrutiny and assurance to the Board.	
Control 3 – Integrated Quality Governance and Organisational Learning The Trust has established integrated quality governance and organisational learning arrangements, including SCIF, Complex Case Panel, Learning from Deaths Forum, CAG and QMG, to bring together intelligence from incidents, concerns, mortality, claims, coronial activity and patient experience, identify themes, support learning and provide assurance regarding quality, safety and patient outcomes.		First Line of Assurance Established governance forums regularly review incidents, concerns, mortality, claims, coronial activity, patient experience and organisational learning to identify themes, monitor improvement actions and provide operational assurance regarding quality and patient safety.	Second Line of Assurance Quality Governance arrangements, supported by MIQPR reporting and the development of the Trust's Quality Management System, provide oversight of trends, themes, risks and improvement actions across incidents, concerns, patient experience and organisational learning, providing assurance regarding the effectiveness of the Trust's quality governance and organisational learning arrangements.		Third Line of Assurance QuEST provides independent scrutiny and assurance to the Board regarding the effectiveness of the Trust's quality governance and organisational learning arrangements.	
GAPS IN CONTROLS			GAPS IN ASSURANCE			
External			External			
1. The national assurance framework and reporting requirements for the Listening to People regulations continue to evolve, limiting the Trust's ability to fully align local controls and governance arrangements with future Welsh Government expectations.			1. National assurance requirements and performance expectations for the Listening to People framework continue to evolve, limiting the Trust's ability to benchmark performance and demonstrate compliance against a mature external assurance framework. The national Beacon dashboard will begin to publish this data from Quarter 2 onwards.			
2. National expectations regarding quality governance, organisational learning and the integration of quality intelligence under the Listening to People framework are continuing to develop across NHS Wales.			2. External assurance arrangements relating to organisational learning, quality governance and the integration of quality intelligence are still developing across NHS Wales.			
3. The Trust has limited influence over the pace and consistency of implementation of Listening to People arrangements across NHS Wales and partner organisations, which may impact shared learning, benchmarking and the delivery of consistent assurance.			3. There is limited national benchmarking information currently available to compare performance, learning and outcomes across NHS Wales organisations operating under the Listening to People framework. The national Beacon dashboard will begin to publish this data from Quarter 2 onwards.			
4. The long-term operational, workforce and financial implications of the Listening to People framework are not yet fully understood across NHS Wales, which may impact the sustainability of local arrangements.			4. There is limited evidence currently available regarding the long-term effectiveness and outcomes associated with implementation of the Listening to People framework across NHS Wales.			
Internal			Internal			
2. Workforce capacity, capability and specialist expertise may be insufficient to sustain the statutory requirements of the Listening to People framework alongside wider organisational transformation and increasing service demand. Workforce impact assessments and demand and capacity assessments are constrained by the limited data available on operational impact and continuing evolution in the profile of complaints cases being managed under the new Stages of the Guidance.			2. Workforce capacity, and alignment of capabilities and specialist expertise is being captured through narrative and anecdotal feedback. Data is required to quantify the altered profile of concerns work and areas of challenge. Similarly, better informed organisational oversight is needed of the quality of responses, such that this intelligence can inform organisational training needs analysis. Once optimal processes for managing concerns are designed and embedded, data-informed demand and capacity assessments will provide organisational intelligence on sustainability.			

Risk ID 700	Failure to implement and deliver the statutory requirements of the revised Concerns Regulations and accompanying ‘Listening to People’ Guidance.		Date of Review:	14/08/2026	TREND	16 (4x4)
			Date of Next Review:	14/09/2026	➡	
3. The maturity and consistency of Early Resolution and Listening Discussion arrangements across the organisation are still developing and require ongoing evaluation to ensure statutory requirements are met and intended benefits are realised.			3. Early Resolution arrangements have been implemented across Service Areas but require further evaluation to provide assurance regarding consistency, effectiveness and delivery of intended outcomes. The impact and effectiveness of Listening Discussions are still being evaluated and there is limited assurance regarding their long-term sustainability and contribution to improved patient experience and organisational learning.			
4. Organisational learning arrangements are not yet fully mature and require further development to ensure learning from concerns is systematically identified, shared and translated into measurable improvement.			3. A comprehensive organisational learning framework is still being developed and there is limited assurance regarding the systematic identification, dissemination and implementation of learning arising from concerns.			
5. Integrated digital systems and performance reporting arrangements are not yet sufficiently mature to provide comprehensive, real-time intelligence and assurance regarding concerns management, organisational learning and statutory compliance.			4. Current digital systems and business intelligence arrangements do not yet provide comprehensive assurance regarding statutory timescales, quality of investigations, organisational learning or reporting requirements under the Listening to People framework.			
6. The future operating model and end to end processes supporting concerns management, organisational learning and quality governance continue to evolve, creating risks to consistency, sustainability and assurance.			5. There is limited assurance regarding the long term sustainability of workforce, operating arrangements and governance structures required to deliver the statutory requirements of the Listening to People framework.			
7. The quality and consistency of investigations, responses and clinical oversight arrangements require further development to ensure a consistent, person-centred approach across the organisation.			6. There is limited internal assurance regarding the consistency and quality of investigations, responses and clinical oversight arrangements across concerns management and organisational learning functions.			
Actions to reduce risk score or address gaps in controls and assurances		Action Owner (Internal only)	Completion / Milestone date	Progress Update		
4. Implement the Concerns Management Improvement Programme – Improvement workstream, This workstream will deliver clarification of roles and responsibilities across the Concerns process; identification of longer-term service and capability improvement related to the concerns process.		CMI Programme SRO Deputy Director of Quality & Nursing	December 2026	Monitored through the Concerns Management Improvement Programme Improvement workstream Measure of success Increased training compliance Staff report feeling confident, capable and well-supported to listen, act, investigate and respond in keeping with the revised Listening to People Guidance. Improving performance across key indicators, aligned to national assurance and performance standards and benchmarked where appropriate against other NHS Wales organisations. Feedback from Patient Concerns Experience Surveys is positive, where people feel heard, understood and believe appropriate learning and improvement has been undertaken. Workforce impact assessment reviewed, demand and capacity assessment completed, training needs analysis completed		
5. Implement the Concerns Management Improvement Programme - Transition workstream. Evaluate and embed Listening Discussions and Early Resolution arrangements across the organisation.		Assistant Director of PTR	January 2027	Monitored through the Concerns Management Improvement Programme - Transition workstream Measure of success Increasing percentage of complaints considered appropriate for early resolution dealt with through the early resolution process Reducing number of Early Resolution cases which convert to formal investigation Feedback provided through the Patient Concerns Experience Survey Evaluation completed and recommendations implemented.		
6. Develop and implement an integrated organisational learning framework to support learning from concerns, (Complaints, Incidents & Claims) patient experience feedback and compliments and Mortality (Medical Examiner feedback and coronial activity)		Assistant Director of PTR	October 2026	Monitored through the Concerns Management Improvement Programme –Improvement Group Measure of success Demonstrable evidence of learning being identified, shared and translated into improvement. Compliance with Welsh Risk Pool Procedures relevant to learning from events. Strong performance in Learning from Event approval rate, with minimal deferred cases and no breached cases. Learning framework approved and embedded through governance arrangements.		
7. Implement the Concerns Management Improvement Programme - Data & Digital Group. This workstream will;		Assistant Director of Digital	October 2026	Monitored through the Concerns Management Improvement Programme – Data & Digital Group Measure of success		

Risk ID 700	Failure to implement and deliver the statutory requirements of the revised Concerns Regulations and accompanying ‘Listening to People’ Guidance.			Date of Review:	14/08/2026	TREND	16 (4x4)
				Date of Next Review:	14/09/2026	➡	
Develop digital systems and performance reporting arrangements to support statutory compliance, organisational learning and integrated quality intelligence. Definition and agreement of metric definitions and supporting data structures aligned to national LtP reporting requirements. Development and implementation of a Trust-wide reporting capability, including Power BI dashboards aligned to WAST LtP metrics. Definition and implementation of access models and permissions across Datix, data warehouse and reporting systems. Identification and escalation of digital dependencies and solution gaps impacting delivery of reporting and assurance.				Improved availability of timely, reliable data and assurance reporting externally, at Board level and throughout floor to Board quality governance forums. Accessible and targeted business intelligence products from floor to Board to assist with case management, caseload oversight, learning and assurance. Agreed reporting framework and digital requirements identified and implemented in phases.			
8.	Review operating model, end to end process redesign and organisational integrated performance and quality governance structure to ensure sustainable delivery of statutory concerns management, quality governance and organisational learning functions.	Deputy Director of Nursing Quality & Governance	October 2026	Monitored through the Concerns Management Improvement Programme –Improvement Group Measure of success Improved resilience, capability and sustainability of services. Improving performance across key indicators, aligned to national assurance and performance standards and benchmarked where appropriate against other NHS Wales organisations. Process mapping workshops Policy and SOP aligned to redesigned pathway and future operating model Development of sustainable governance and Concerns learning arrangements			
9.	Continue engagement with Welsh Government and NHS Wales national groups to influence and respond to emerging requirements associated with the Listening to People framework.	Deputy Director of Nursing Quality & Governance /Assistant Director of PTR	October 2026	Measure of success Demonstrable alignment with national expectations and external assurance requirements. Emerging national guidance and assurance requirements incorporated into local arrangements.			

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:		04/08/2026	TREND	15
				Date of Next Review:		04/09/2026	➡	(3x5)
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: 1 Providing the right care or advice, in the right place, every time								
EXECUTIVE OWNER		Director of Operations		ASSURANCE COMMITTEE		Finance & Performance Committee		
Risk Commentary The challenges across the unscheduled care system. Handover lost hours in June were 13,871 and July were 9,931 . 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 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. June26 - short of any testing or exercising we have exhausted all internal actions and therefore the ELT/Board have agreed to tolerate the current score and continue escalation through appropriate routes. There are no further actions to explore for this risk.								
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.				
				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.				

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:	04/08/2026	TREND	15
			Date of Next Review:	04/09/2026	➡	(3x5)
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 11 th 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. 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		

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:	04/08/2026	TREND	15
				Date of Next Review:	04/09/2026	➡	(3x5)
				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 (6 th 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. Kidwelly Major Incident	Assistant Director of Operations, Emergency Operations	September 2026		August 2026 – Undertaking exploratory work to understand the immediate release during the major incident against all required standards for all acute Trusts.			

Risk ID 706	The Trust’s inability to maintain preparedness for a pandemic response causing patient harm and death			Date of Review:		12/08/2026	TREND	15 (3x5)
				Date of Next Review:		12/08/2026	➡	
IF the Trust is unable to maintain preparedness for a response to a pandemic		THEN there is a risk of inability to respond to patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence		Score
				Inherent				
				Current	3	5		15
				Target	2	5		10
Strategic Objective:								
EXECUTIVE OWNER		Executive Director of Operations		ASSURANCE COMMITTEE		Quality, Safety and Patient Experience Committee		
Risk Commentary								
Pandemics are usually the result of a novel pathogen (virus, bacteria, fungi or other organisms that cause disease) emerging and spreading quickly around the world due to lack of population immunity. Experts consider a respiratory pathogen to be the most likely cause of a future pandemic affecting the UK, based on the emergence of pandemics since 1900 and, as such, assumptions based upon a respiratory disease underpin the reasonable worst-case scenario for UK and Welsh government pandemic preparedness planning. However, the government continues to plan and prepare for a range of pandemic and emerging infectious disease scenarios, across the five different transmission routes: respiratory, blood and sexual, touch, oral (food and water) and by vectors such as mosquitos. This approach covers known or unknown pathogens (referred to as “Disease X” by the World Health Organisation). The National Risk Register 2025 scores the risk of Pandemic as Impact – 5 / Likelihood 4, reflecting the very high risk of the UK facing a future pandemic. The reasonable worst-case scenario is based on an unmitigated respiratory pandemic with an unassumed transmission route and a high attack rate, with 4% of symptomatic infections requiring hospital care and a case fatality ratio of 2.5%. From start to finish the emergency stage of the pandemic in the UK will last at least 9 months and potentially significantly longer. The pandemic may come in single or multiple waves. The scenario assumes 50% of the UK’s population fall ill during the whole course of the pandemic, with about 1.34 million people estimated to require hospital treatment, possibly resulting in up to 840,000 deaths. Within Wales the Wales Risk Group has assessed the risks pertinent for Welsh communities. The risk of a Pandemic is assessed as a very high risk and subsequently the four Local resilience forums have been tasked to consider the partnership response to a pandemic. For a very high risk such as a pandemic, no response can be affectively achieved without a joined-up response from all agencies, however individual organisations need to maintain pandemic preparedness to ensure their organisation can respond effectively. In the event of a pandemic WAST will be expected to provide a frontline NHS response to the communities of Wales as well as maintaining its obligations to our commissioners and to the Civil Contingencies Act 2004. NHS Wales (NHSW) reviews the NRR and assesses the impact on the NHS partners within Wales, the risk of Pandemic has been assessed and deemed a very high risk. While pandemic response is inherently system-wide, WAST retains direct accountability for the preparedness of its workforce, fleet, infection prevention controls, and operational response arrangements in line with its statutory duties. Alongside formal plans, equipment, and surveillance mechanisms, the Trust’s ability to respond effectively is shaped by workforce capacity and resilience, including the management of significant staff absence, redeployment, and sustained operational pressure.								
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.						
6. National Risk Register		1. The National Risk Register (NRR) is released to the public and therefore available to the Trust and can be accessed at any time.						
7. LRF Community Risk Register		2. The four LRFs within Wales all have Risk Sub-groups to evaluate the NRR and ensure local planning takes place to mitigate the risk as far as is reasonably practicable. WAST has members of the Trust’s EPRR team working with partners, as part of the four LRF risk sub-groups.						
8. NHSW Risk Register		3. NHSW has a risk sub-group being set up, reporting to the Emergency Partners Assessment Group (EPAG). The Trust’s Head of Service, EPRR & Specialist Operations sits with partners on EPAG and is supportive of providing a member of the EPRR team to sit on the Risk sub-group once it is established.						
9. Welsh Risk Register – Official Sensitive		4. Welsh Risk Register is derived from the NRR which guides LRF risk assessment arrangements specific to Wales						
5. National and local exercising		5. Nationally run exercises (Exercise Pegasus) which reaches into local LRF levels of participation.						
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						

Risk ID 706	The Trust’s inability to maintain preparedness for a pandemic response causing patient harm and death		Date of Review:	12/08/2026	TREND	15 (3x5)
			Date of Next Review:	12/08/2026	➡	
Control 1 – Pandemic Plan WAST have a current Pandemic Outbreak plan. The current version was approved in October 2025. Outputs from reviews, debriefs and exercises are documented, and any required amendments are incorporated into subsequent plan iterations.		First Line of Assurance Pandemic plan is reviewed by the EPRR team every 3 years, or following an exercise or live plan activation to ensure the plan is current and up to date. Plan is signed off by Head of Service, EPRR & Specialist Operations and managed via the trust governance processes. The EPRR team have a presence on each of the Risk Groups that form part of the four LRFs in Wales. This review of the Welsh Risk Register and adaption for local level planning informs any changes required to WAST internal plans. A series of exercises have been planned for the coming 3yr period to test and exercise key elements of the WAST Pandemic plan in isolation followed by a whole plan test. This is being monitored by EPRR Via the RMG.	Second Line of Assurance The Pandemic Plan is formally reviewed and approved through the Senior Operations Team (SOT), with oversight provided by the Senior Leadership Team (SLT). Any material gaps, learning from exercises, or changes in national guidance are escalated through SOT with agreed actions and timescales, and progress monitored through routine operational governance. EPRR Debriefs to formally review exercising.		Third Line of Assurance NHSW assurance required on an annual basis as part of the EPRR assurance provided to Welsh Government. The Pandemic Plan forms part of the Trust’s annual EPRR assurance submission to NHS Wales and Welsh Government. This includes independent scrutiny of preparedness arrangements, with any significant deficiencies or improvement actions formally fed back to the Trust and tracked through the EPRR governance framework until resolved.	
Control 2 – Pandemic PPE stock WAST maintains a store of pandemic specific PPE that can be distributed across the Trust when required. This stock is managed by the Clinical Logistics department. Pandemic PPE stockholding arrangements are maintained in line with national guidance, with defined responsibilities for stock management, rotation, and replenishment.		First Line of Assurance The WAST stock Inventory list is a Live document that is updated daily. A full stock take is undertaken every six months.	Second Line of Assurance Stock levels held by WAST are reported to the Assistant Director of Clinical Delivery.		Third Line of Assurance All Wales storage availability In line with WHC-2025-023, NWSSP on behalf of NHS Wales hold the following (based on usage during the winter of 2020/21) 12 weeks supply of - splash proof aprons - face shields/visors - Type IIR Fluid Resistant Surgical Masks (FRSM) - Full body fluid repellent gowns - Hand sanitiser/wipes 16 weeks supply of - Respiratory Protective Equipment - Medical Grade Examination Gloves	
Control 3 – RPE training/monitoring WAST staff have been trained in the use of Powered Air-Purifying Respirators (PAPR) rather than FFP3 masks due to the high failure rate associated with FFP3 fit testing. The E&D team deliver PAPR training on induction to the Trust. The IP&C team provide FFP3 fit test training to volunteers.		First Line of Assurance Ownership of PAPR and donning/ doffing training has been transferred back to the Infection Prevention and Control (IP&C) team. Plans are underway to mandate training via ESR to enable Trust-wide compliance reporting, with assurance provided through quarterly IP&C Strategic Group meetings. This strengthens pandemic preparedness by enabling workforce readiness, consistent RPE competency, and Trust-wide compliance monitoring to support a rapid and safe outbreak response.	Second Line of Assurance The PAPR SOP and associated donning and doffing action cards are subject to regular review and updated in line with emerging national guidance and best practice. The PAPR and donning/ doffing training programme is also routinely evaluated to ensure it remains current, effective, and aligned with evidence-based standards.		Third Line of Assurance Local operational teams have designated RPE champions who support delivery of refresher training within their areas. The IP&C team provides regular updates on changes to guidance to ensure training remains current and consistent. In addition, the IP&C team will undertake annual quality assurance of training delivery to confirm adherence to standards and effectiveness.	
Control 4 – Pandemic emergence monitoring Once the pathogen emerges it is crucial to gain a rapid understanding of the spread, transmission, symptoms, severity, immunity, treatments and healthcare pathways.		First Line of Assurance The IP&C team interpret emerging national guidance and integrate it into the organisation’s pandemic response plans, operational pathways, and emergency command structures.	Second Line of Assurance The WAST IP&C team are represented on the National Ambulance Service Infection Prevention Control Group (NASIPCG) and the Lead Infection Prevention Control Group for Wales. This facilitates the timely sharing of information relating to emerging pandemics across Wales		Third Line of Assurance NHSW hosted Welsh Health System Resilience Monitoring partnership provides system-level scrutiny and shared intelligence on emerging health threats, offering independent assurance on	

Risk ID 706	The Trust’s inability to maintain preparedness for a pandemic response causing patient harm and death		Date of Review:	12/08/2026	TREND	15 (3x5)
			Date of Next Review:	12/08/2026	➡	
	The IP&C team receive updated guidance via Public Health Wales, ensuring timely awareness of transpiring requirements. This ensures timely organisational awareness and supports informed decision-making during the early stages of a pandemic. The EPRR & Specialist Operations Head of Service will engage with PHW Incident Management Team during identification of emerging pathogens. There will also be an EPRR link to the Welsh Government Systems Resilience Planning and Response Group as a horizon scanning and response framework across WAST and the wider NHS Wales.	and nationally, strengthening coordinated response and situational awareness. WAST EPRR team are represented on the UK national EPRR meetings, this includes the EPRRG, the EPRRDG and the EPRRBC groups. This link into ambulance services across the UK allows for a shared situational awareness of emerging pandemics. Participation in these national and UK-wide forums provides assurance that WAST maintains situational awareness aligned with emerging intelligence and peer services, enabling coordinated and proportionate response planning.	collective preparedness and escalation across Wales. WAST is a standing member of this group.			
Control 5 – Vehicle Cleanliness	First Line of Assurance - Vehicle daily checks. - Spot checks by local teams. - Make ready processes. - standard daily cleaning - enhanced decontamination after suspected/confirmed infectious cases - outbreak / pandemic-specific escalation cleaning arrangements	Second Line of Assurance Audits Monthly Spot Check Compliance reported through EMG (Emergency Ops Management Group)				
GAPS IN CONTROLS		GAPS IN ASSURANCE				
External		External				
1. Accessing of Welsh pandemic medicines and PPE		1. A lack of clarity exists on how the Welsh national stocks of medicines and PPE can be released and, on the authority, required to release the national stocks. This was done through the Pandemic SPT structure during COVID and the standing up of logistic cells				
2. Links between Welsh and UK government		2. The Covid-19 inquiry has identified that stronger collaboration is required between devolved and UK governments.				
3. Consistent modelling across UK for pandemic spread		3. The Covid-19 inquiry has identified that consistent modelling across all nations of the UK is required and stronger cooperation within SAGE would assist decision makers.				
Internal		Internal				
4. Broaden testing and exercising of the pandemic plan.		8. The Trust’s review of the Manchester arena inquiry identified that the current EPRR team’s capacity does not allow for the levels of testing and exercising required for all Trust response plans. This is the case for the pandemic plan. Requests to enhance the Trust’s EPRR team have been submitted to commissioners.				
9. Ongoing PAPR/donning and doffing training.		2. While staff receive PAPR and donning and doffing training at induction, refresher training has not been in place to date. Plans are underway to address this through mandatory annual training via ESR, led by IP&C and supported by operational respiratory protection equipment champions.				
10. Maintenance of PPE.		3. Gap in assurance identified via IP&C audits, including expired PPE stock and inconsistent completion of three-monthly PAPR maintenance checks. Improved stock control systems and maintenance processes are required to support operational preparedness. The process for volunteers is yet to be agreed; historically, FFP3 training was delivered by the IP&C team, but this requires further discussion.				
Actions to reduce risk score or address gaps in controls and assurances	Action Owner (Internal only)	Completion date	Progress Update			
10. Ensure any updates from EPAG in relation to how the Welsh National Stockpile is accessed is reflected within the WAST Pandemic plan.	HOS EPRR & Specialist Operations	Complete	This is reflected in the Pandemic Plan			
11. Ensure any updates from Welsh Government on its UK coordinated response	HOS EPRR & Specialist Operations	Complete	Both the WAST incident response plan and the WAST pandemic plan complement each other and refer to the UK coordinated response arrangements			

Risk ID 706	The Trust’s inability to maintain preparedness for a pandemic response causing patient harm and death			Date of Review:	12/08/2026	TREND	15 (3x5)
				Date of Next Review:	12/08/2026	➡	
arrangements are incorporated into the WAST incident response plan to compliment the WAST pandemic plan.							
12. Ensure responsibility for training Trust staff is transferred to the IPC team.		Head of Infection, Prevention and Control	Complete	Already handed back to IPC team			
13. Ensure continuation training in the use of PAPR/donning and doffing is introduced across all patients facing staff groups.		Head of Infection, Prevention and Control	September 2027				
14. Ensure assurance is in place and visible across directorates for the levels of Pandemic PPE held by the Trust		Assistant Director of Clinical Delivery	Complete	Levels were agreed at ELT in 2024 for ambulance specific PPE. Local operational teams are aware. 6 weeks stock of coveralls, shoes and aprons are stored centrally in Clinical Logistics			
15. The creation of Action Cards for the IRD		Assistant Director or Operations, National Ops & Support	March 2027	IRD will be up and running. OM will be appointed to take this work forward			
16. Completion of the 12 Month Pandemic Exercising post Pegasus (Commencing September 2026)		HOS EPRR & Specialist Operations	September 2027				
17. Pandemic Inquiry outputs and pandemic response (Module 3)		Assistant Director of Corporate Governance and Risk	September 2026	PGG overview of reports and identify any areas for consideration within WAST. Consider other module reports			
18. Maintenance of PPE		Head of Infection, Prevention and Control and local management teams	March 2027	NEPTS, Ambulance Care, EMS teams – joint approach			

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:		12/08/2026		TREND	12
			Date of Next Review:		12/11/2026		➡	(3x4)
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: 4 Developing services in collaboration								
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, is not being achieved across the three commissioned patient pathways currently as evidenced by the call abandonment rate & P2/P3 performance in the 111 service, the wait times for Emerg and Orange in the emergency ambulance care pathway and the level of cancellations in the Ambulance Care, specifically NEPTS patient pathway. The Trust reports the specific quality and performance issues on these in its monthly integrated quality & performance report. As part of its 2026-29 IMTP development the Trust has reflected the JCC’s commissioning intentions for 2026/27 in its plans and set out its ambitions in a quantified form, through a report to Trust Board (26 March 2026) recommending a revised set of top metrics for Trust Board, cross referenced to the Trust’s strategic objectives, with supporting ambitions (benchmarks, performance ranges, level of quality etc.). Like every part of NHS Wales, the Trusts’ IMTP reflects a more challenging financial environment, with no new monies to support investment in support of the strategic objectives. So, whilst the JCC is broadly supportive of the Trust’s ambitions, there is no new commissioned monies in support of them. The Trust has plans to re-invest internal monies in support of its ambitions, which will be subject to business cases with the JCC. Within the construct of less monies, productivity is, unsurprisingly, becoming more important. The JCC is currently undertaking a strategic review, which is wider than just productivity, but this is another aspect of the changing environment that the Trust is now interfacing with the JCC on. 12.08.26 This risk is to be reframed as a single commissioning-related risk, focused on the absence of an appropriate commissioning and contractual framework, including clear expectations, accountability and funding arrangements.								
CONTROLS			ASSURANCES					
			Internal & External Management (1 st 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			2. Minutes of meetings and a standard agenda item. Sub-committees now established.					
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 JCC reps co-opted e.g. New Ambulance Performance Framework.					
5. Joint WAST Executive/JCC SLT Monthly Meeting			5. This has restarted by is not embedded yet.					
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.			7. Quarterly progress is reported to ELT/STB and onto a JCC sub-committee.).					
8. Governance arrangements for JCC Committee, Ambulance & 111 Commissioning Management Group, NEPTS CAG and 111 CAG			8. Minutes of meetings and a standard agenda item					
			External Management (1 st Line of Assurance) 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available					

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:	12/08/2026	TREND	12
			Date of Next Review:	12/11/2026		(3x4)
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. 20/03/26 The financial pressures across the system and on the JCC through this budget round do suggest that JCC time to focus on WAST is compressed, however, day to day relationships between WAST and the JCC team remain strong.				
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. 20/03/26 The Commissioning & Performance Team does now have a greater ability to service JCC requests and co-ordinate internally within WAST. Generally, as the monetary situation tightens, the Trust is servicing more requests and more meetings, and this is expected to remain the case, increase.				
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. 20/03/26 There has been an improvement in handover lost hours, but the Trust still had an average loss of >15,000 hours in 2025/26 YTD. The Trust will continue to influence in this space, particularly as part of the productivity debate, because the biggest productivity gain for the Trust, as set out in its IMTP, would be W45 or even better W45.				
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 a review of WAST during the remainder of Q3 and into Q4. 20/03/26 There are recognised imbalances between demand & capacity across the three commissioned patient pathways. The 2026-29 IMTP contains various planned mitigations e.g. 111 digital front end, further capacity in the 999/EMS remote clinician space, options for NEPTS etc.				
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. 20/03/26 The JCC has requested business cases for the proposed IMTP reinvestments in the 2026/29 IMTP.		

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:	12/08/2026	TREND	12
				Date of Next Review:	12/11/2026	➡	(3x4)
2. Agree and influence JCC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	IQPD 12/02/25 The APHID is a WG led group, so timeframe is dependent on WG.	26/04/24 This modelling has been further supplemented by modelling the Ministerial target of no handovers of more than one hour. 26/06/24 May-24 levels at 24,000, which is higher than 2023 and concerning as an indicator of the winter the Trust may expect. Trust moving at pace to evolve clinical response model, with Welsh Government full sighted on impact of handover hours on the Trust. 21/01/25 The Trust experienced 26,000 ambulance unit hours lost to hospital handover in December 2025, in line with its prediction, but significantly above the WG target of no waits over one hour, which equates to approximately 7,500 hours. 14/04/25 WG has now established an Ambulance Patient Handover Improvement Implementation (APHID) Group to take forward this ambition. 19/08/25 This has led to the W45 initiative i.e. 45 minute handover, with handover lost hours in July 2025 being their lowest since July 2021. A continued focus by health boards is required to achieve the ambition and sustain it. 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. 20/03/26 Handover lost hours have reduced but averaged 15,000 hours through 2025/26 YTD. W45 would require this figure to be more than halved.				
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. 20/03/26 WAST has presented options to the JCC on how to improve capacity and the number of patients reached by NEPTS. The Trust is currently undertaken a complex and difficult re-rostering of NEPTS, which will have a material impact on capacity, but will not be sufficient on its own. Further traction is required in this space, including actions by health boards and decisions by the JCC/WG.				
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.				

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:	12/08/2026	TREND	12
				Date of Next Review:	12/11/2026	➡	(3x4)
				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 20/03/26 This meeting is now up and running, but it remains early days. As per previous remarks the day-to-day relationships between the Trust and the JCC ambulance & 111 commissioning team remain strong, but executive churn in the JCC has made establishing a good rhythm of business with the wider JCC more challenging.			
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. 20/03/26 Further consideration needs to be given to how WAST can influence and engage with the JCC. The Executive Director of Strategy, Planning & Performance has identified this as a key action for the Commissioning & Performance Team during 2026/27.			

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation		Date of Review:		29/07/2026		TREND	12 (3x4)
			Date of Next Review:		29/10/2026		➡	
IF the Trust does: - not achieve financial breakeven and/or - does not meet the planning framework requirements and/or - does not work within the Capital Expenditure Limit and/or - fails to meet the 95% PSPP target and/or - does not receive an agreement with commissioners on funding			THEN there is a risk that the Trust will fail to achieve all its statutory financial obligations, and the requirements as set out within the Standing Financial Instructions (SFIs)	RESULTING IN potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage		Likelihood	Consequence	Score
					Inherent	3	4	12
					Current	3	4	12
					Target	2	4	8
IMTP Deliverable Numbers: 9, 12, 15, 18, 24, 25, 30, 31, 32								
Strategic Objective: 6a Financial Sustainability								
EXECUTIVE OWNER			Executive Director of Finance and Corporate Resources		ASSURANCE COMMITTEE		Finance and Performance Committee	
Risk Commentary: WAST has submitted a financially balanced plan for the financial year 2026/27 within its IMTP which includes a savings target of £9m (highest value ever targeted to be achieved) with £1.2m of this identified as ‘pipeline’ and hence yet to be fully identified (if needed to be delivered in 26/27 to support financial balance). WAST is currently seeing the continued impact of the increase in fuel prices (although declined over last 6 weeks but remains volatile) which is significantly more than that included in the balanced financial plan and hence any continuation of this will need to be factored in and mitigated. NHS Wales (and other public sector organisations) financial position is also one of concern and may impact on WAST if further cash releasing efficiencies are required as the financial year progresses. Risk score increased from 10 to 12 and this has been updated after ELT approval on 27 th May 2026.								
CONTROLS			ASSURANCES					
			Internal Management (1 st 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					
4. Regular financial reporting to ADLT, EFG, ELT, FPC and Trust Board in place			4. Diarised dates for FPC, Trust Board and monthly reports with budget managers. EFG meetings will be scheduled as required as the financial year progresses. discussions and reporting will continue through ELT.					
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. FSPB 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 and diarised meetings with NWSSP					
10.Forecasting of revenue and capital budgets			a) Monthly monitoring returns to FPC, Trust Board and circulated out of committee to Board members (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 (1 st 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 (3 rd Line of Assurance)					

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation		Date of Review:		29/07/2026	TREND	12 (3x4)
			Date of Next Review:		29/10/2026	➡	
			1-10 Internal audit reviews covering				
			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		31/03/27	Supported financial plan included in IMTP for 26/27. 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		31/03/27	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 25/26 financial year and the point of strong delivery. 25/26 target is £9m of which £1.2m is pipeline savings planned to be identified and commence from Qtr. 2.		
3. Embed value-based healthcare working through the organisation		Executive Leadership Team and Value Based Healthcare Group		31/03/27	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues. JCC services review has commenced that identifies service line costs as well as noncash releasing efficiency gains.		
4. Foundational economy, Decommissioning, and procurement to mitigate social and economic wellbeing of Wales		Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership		31/03/27	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.		

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships			Date of Review:		27/07/2026		TREND	12 (4x3)
				Date of Next Review:		27/10/2026		➡	
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: 2 Enabling our people to be the best they can be									
EXECUTIVE OWNER		Director of People		ASSURANCE COMMITTEE		People & Culture Committee			
Risk Commentary									
Failure to maintain effective and constructive social partnership arrangements with Trade Union partners may reduce the Trust's ability to engage meaningfully on workforce issues and organisational change, compromising delivery of Strategic Objective 2 and affecting workforce stability, employee experience and service delivery. The risk reflects the potential impact of deteriorating industrial relations, reduced trust and engagement, or an inability to achieve timely resolution of workforce issues. This could affect the Trust's ability to implement change effectively, maintain constructive employee relations and sustain a positive organisational culture. The score is maintained at 12 (3x4). 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.									
CONTROLS				ASSURANCES					
				Internal Management (1 st 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. Trade Union representation at Trust Board, Committees				3. 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					
4. Monthly Informal Lead TU representatives and Chief Executive meetings				4. Diarised meetings					
5. TU partners in Task & Finish and Project Groups				5. Good attendance and commitment are observed at the meetings. TU partners listed as members in terms of reference					
6. 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				6. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings					
7. Quarterly Report on TU activity to People and Culture Committee				7. 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 Triple A reports through to WASPT and to PCC. Any escalations are appropriately noted.					
8. Recommending closure on this at WASPT in August. ACAS report from 2022 actions mainly complete with handful of elements moving into BUA.				8. Development of mentoring and training opportunities for TUPs to support their roles. Action plan implementation completed with actions moved to BAU					
9. AAA report of formal Partnership Forum (WASPT) reported to PCC or Board in future (return to BAU).				9. Training for managers and TUPs delivered					
10. AAA from SLT Partnership Forum and Corporate Partnership Forum reported to WASPT				10. Stability in senior TU team					
11. Rhythm of meetings to curate and focus on relationships				11. AAA, minutes, monthly sessions with CEO, DoP and DoO. Informal sessions with CEO, DoP and Branch Chair and Sec on a quarterly basis. 6 weekly meetings with DoP on other partnership forum arrangements.					
12. Increased mutual respect and TU partner understanding and appreciation of challenges and pressures facing the Trust				12. Regular conversations in place on relationships and meeting reviews					
13. Rollout of partnership training across WAST now to be extended to first line managers - complete				13. Four Social Partnership training days delivered.					

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships			Date of Review:	27/07/2026	TREND	12 (4x3)
				Date of Next Review:	27/10/2026		
14. 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.				14.			
15. Task and Finish group to be established to work on mitigating the impact of EAP Band 5 post introduction and wider skill mix discussions. - Complete				15. Complete: Email to TUPs from Director of Strategy and Planning. Meetings completed business case in development for feedback to ELT			
16. Output from Conference informing next steps in developing maturity of relationship				16. Under review, gathering feedback from delivered Social Partnership training days			
17. Learning and Development opportunities for TU partners e.g. shadowing, digital skills, coaching and mentoring, EDI and Speaking up Safely				17. Complete: 15/01/26: Online learning on 365 published and advertised via Siren. This is now BAU.			
18. Develop consultation guidance for managers. Replaced through SP training delivery.				18. Complete: 15/01/26: This has been incorporated into the OCP guidance and updated to SharePoint in September.			
19. Produce a report for ELT with a range of options on Skills Mix – Completed.				19. Complete: 15/01/26: 3 rd and final report to ELT 14/01/26. Managers briefing session in the diary prior to WAST Live on 31/01/26			
GAPS IN CONTROLS				GAPS IN ASSURANCE			
In maintenance and further improvement mode				None identified			
Actions to reduce risk score or address gaps in controls and assurances			Action Owner	By When/Milestone	Progress Notes:		
TU Partner development in key areas of EDI, Speaking up Safely and Safeguarding.			Deputy Director of People	Q4 2026/27	Update 19/06/26: TUPs are signposted to access the EDI training on offer across WAST e.g. bystander training. Safeguarding training has been delivered through the Social Partnership Training Days. Training for SUS is being developed. Further time is needed due to team capacity to undertake the work. Update13/07/26: TUPs are signposted to access the EDI training on offer across WAST e.g. bystander training. Safeguarding training has been delivered through the Social Partnership Training Days. Training for SUS has been developed. Delivery will be scheduled for September.		

Risk ID 708	Failure to secure timely access to patients in locked or inaccessible premises due to unclear inter-agency responsibilities and absence of enforceable escalation arrangements		Date of Review:	12/08/2026		TREND	8 (2x4)
			Date of Next Review:	12/11/2026		↓	
IF there is inconsistent inter-agency agreement, mobilisation behaviour, and escalation arrangements between Ambulance, Police and Fire & Rescue Services regarding responsibility for gaining entry to premises, including variability arising from the application of the ‘Right Care, Right Person’ initiative beyond mental health presentations, and no consistently enforceable mechanism to resolve disputed agency responsibility at scene.	THEN there is a risk of delay or failure in gaining timely access to patients in locked or inaccessible properties, leaving ambulance crews unable to provide welfare or clinical assessment or treatment despite reasonable belief of risk to life,	RESULTING IN delayed clinical assessment and treatment, inability to confirm patient welfare, patient deterioration or death, increased serious incidents, coronial and regulatory scrutiny, moral injury and professional risk to staff, legal and reputational risk to the Trust, and unsafe expectations being placed on ambulance staff who do not hold statutory powers of entry.		Likelihood	Consequence	Score	
			Inherent				
			Current	2	4	8	
			Target				
Strategic objective: Providing the right care or advice, in the right place, every time							
EXECUTIVE OWNER		Executive Director of Operations	ASSURANCE COMMITTEE		Quality, Safety and Patient Experience Committee		
Risk Commentary							
This risk has been escalated to reflect continued concern that ambulance clinicians may be unable to secure timely access to patients in locked or inaccessible premises where there is reasonable belief of risk to life, but where inter-agency responsibilities for entry, attendance and escalation remain insufficiently clear or consistently applied. Although a pan-Wales interim JESG operating model was introduced from 1 April 2026 to improve role clarity and establish Fire and Rescue Services as the primary agency for gaining entry, these arrangements are time-limited and remain subject to local interpretation and operational variability, particularly where agency thresholds differ or attendance is disputed. Early review following implementation has not identified immediate adverse incidents linked to the new arrangements; however, current assurance remains limited and largely retrospective. As a result, the Trust remains exposed to residual patient safety, staff welfare, legal and reputational risk, and further work is required to evaluate the interim model, strengthen system assurance and establish sustainable longer-term arrangements. The current score							
12.08.26 The current score has been reduced from 20 to 8 to reflect the interim controls now in place, with a further review required if permanent arrangements are not secured and any remaining gaps to be captured as actions.							
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.				
Control 1 - Pan-Wales JESG Interim Operating Model (from 1 April 2026)			1. Fire & Rescue Service designated as the primary agency for gaining entry to premises. Police attendance reserved for crime scenes, staff safety threats, or securing premises post-entry. Police contractor responsible for securing premises once access is gained. This provides system-level role clarity and aims to reduce delay and ambiguity.				
Control 2 - Right Care, Right Person (RCRP) Programme Oversight			2. National framework intended to clarify agency roles and reduce inappropriate deployment, now explicitly linked to property access arrangements beyond mental health incidents.				
Control 3 - Operational Escalation via EMSC and Duty Managers			3. Reinforced clinical and operational escalation processes for crews unable to gain access, supporting senior decision-making, dynamic risk reassessment and partner agency engagement where ongoing concern for patient welfare exists.				
Control 4 - Serious Case Incident Forum (SCIF)			4. Routine review of near-misses and serious incidents relating to access delays, with learning disseminated internally.				
Control 5 - Clear Position on Statutory Powers of Entry			5. Explicit reinforcement of operational guidance and legal clarification that ambulance services do not hold statutory powers of forced entry, reducing the risk of unsafe, unlawful or professionally unsupported actions and expectations being placed on staff.				

Risk ID 708	Failure to secure timely access to patients in locked or inaccessible premises due to unclear inter-agency responsibilities and absence of enforceable escalation arrangements	Date of Review:	12/08/2026	TREND	8 (2x4)
		Date of Next Review:	12/11/2026	↓	
MITIGATE - Internal <i>How do we know the controls are effective. How will these impact the target risk score?</i>		Internal <i>over the three lines of assurance. How do we know the assurances are effective</i> <i>Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk</i>			
Control 1 – Operational Escalation via EMSC and Duty Manager - Reinforced clinical and operational escalation processes for crews unable to gain access, supporting senior decision-making, dynamic risk reassessment and partner agency engagement where ongoing concern for patient welfare exists.		First Line of Assurance - Response Coordination SOP Section 7.2 - Operational notice 2026-020 - Managing Delayed Response SOP – Section 6	Second Line of Assurance - Internal review through operational management meetings - DATIX Incident Reviews	Third Line of Assurance Oversight through Joint Emergency Services Group (JESG) and pan-Wales task-and-finish arrangements, with external scrutiny through coronial processes and nationally reportable incidents where delays to access are identified.	
Control 2 – Serious Case Incident Forum (SCIF) - Routine review of near-misses and serious incidents relating to access delays, with learning disseminated internally.		First Line of Assurance Routine review of access-related incidents, near-misses and local learning themes through operational governance arrangements and SCIF, with any immediate concerns escalated for action.	Second Line of Assurance Review of access-related incidents, near-misses and learning themes through SCIF and quality meetings.	Third Line of Assurance External scrutiny through coronial processes and nationally reportable incidents provides additional assurance where delayed access is identified as a contributory factor.	
Control 3 – Clear Position on Statutory Powers of Entry - Explicit reinforcement of operational guidance and legal clarification that ambulance services do not hold statutory powers of forced entry, reducing the risk of unsafe, unlawful or professionally unsupported actions and expectations being placed on staff.		First Line of Assurance - Response Coordination SOP Section 7.2 - Managing Delayed Response SOP – Section 6 - Operational Notice 2026-020	Second Line of Assurance - Internal review through operational management meetings - DATIX Incident Reviews	Third Line of Assurance Oversight through Joint Emergency Services Group (JESG) and pan-Wales task-and-finish arrangements	
Control 4 – Pilot monitoring and incident review following go-live from 1 April 2026, including checks for adverse incidents and Datix reports relating to failure to access property.		First Line of Assurance Operational checking undertaken to confirm whether problems with entry to premises have continued since the pilot started on 1 April 2026.	Second Line of Assurance - DATIX Incident Reviews Meetings - Operational Management Meetings	Third Line of Assurance Oversight through Joint Emergency Services Group (JESG) and pan-Wales task-and-finish arrangements	
GAPS IN CONTROLS			GAPS IN ASSURANCE		
External			External		
1. Reliance on Interim (Time-Limited) Arrangements					
2. The JESG operating model is a six-month trial			2. There is a risk of reversion to inconsistent behaviours once the pilot ends if not formally embedded. Despite interim operating arrangements, the Trust remains exposed to residual patient safety and reputational risk where partner agencies decline attendance or operational thresholds for intervention differ.		
3. Operational Variability Across Regions and Shifts			3. Inconsistent interpretation and application of roles by Police and Fire control rooms, particularly out-of-hours and under system pressure.		
4. Limited Real-Time Enforcement Mechanism			4. No single authority to compel partner attendance when thresholds are disputed, leaving crews exposed at scene.		
5. Delays may disproportionately affect vulnerable or socially isolated individuals, including elderly patients, safeguarding cases and those with mental health or cognitive impairment, where inability to gain access delays welfare assessment and intervention.			5. Despite interim operating arrangements, the Trust remains exposed to residual patient safety and reputational risk where partner agencies decline attendance or operational thresholds for intervention differ.		
6. Public expectation / reputational risk			5. Public understanding of emergency service roles and legal powers of entry remains limited, creating potential reputational and confidence risks where emergency service attendance does not result in immediate access to premises.		
Internal			Internal		
1. Limited Quantified System-Wide Data on Access Delays			1. Near-misses and access delays are identified through incident review but are not yet routinely quantified or trended at pan-Wales level or in a way that is visible to multiple agencies.		

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2. Dependence on Retrospective Assurance			2. Assurance is currently derived predominantly following harm, near-misses, serious incidents or coronial scrutiny, with limited proactive system performance measures or real-time multi-agency oversight arrangements currently in place No formal all-Wales escalation or arbitration mechanism currently exists where partner agencies dispute responsibility for attendance or gaining entry at scene.			
Actions to reduce risk score or address gaps in controls and assurances			Action Owner (Internal only)		Completion / Milestone date	Progress Update
1. Convert the Interim arrangements into a permanent solution			Assistant Director of Operations, Coordination & Integrated Care			