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:	12/05/2026	TREND	20 (4x5)
		Date of Next Review:	12/06/2026	➡	

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

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

IMTP Deliverable Numbers:

Strategic Objective: 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.

This Board Assurance Framework (BAF) extract is supported by a more detailed appendix of itemised actions required to permit greater scrutiny of remaining gaps and actions, as well as a detailed repository of control measures that have been successfully implemented.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Forty-six (46) of the pertinent MAI Recommendations have been implemented into WAST practice through the work undertaken to date.	1. MAI recommendations that have been marked as implemented by the EPRR MAI Project are authorised and ratified by Operations Senior Leadership Team and cascaded via the approved governance route (AAA) to ELT and Trust Board. This forms a documented governance route for rationale for completion and details of this are recorded in the EPRR share drive alongside evidence of compliance. Additional details of assurance are provided in the annex to this Corporate Risk. Ongoing monitoring and assurance of lessons learned is captured through BAU processes and the established debriefing/lessons learned process such as the Organisational Learning Spreadsheet.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Two (2) outstanding MAI Recommendations, identified as pertinent to WAST by the self-assessment, require action against to implement the associated learning **(REF: MAI recommendations** 26 & 88). These are not included in the R106 funding request.	1. Work is progressing against these recommendations as part of the ongoing MAI project. It is anticipated that these recommendations can be implemented without additional financial support. Regular updates on these four recommendations are provided through the regular 'touch point' meetings with EPRR HoS, ADO for National Operations & ED of Ops, with periodic updates to SLT that are then cascaded via the approved governance route.
2. Eighteen (18) outstanding MAI Recommendations that have been submitted to Trust commissioners via the 'R106' process as	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

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:	12/05/2026	TREND	20 (4x5)
		Date of Next Review:	12/06/2026	➡	

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).**	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 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	15/05/2026	TREND	16 (4x4)
		Date of Next Review:	15/06/2026	➡	

IF there is a lack of resources and available technology and infrastructure	**THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	**RESULTING IN** negative environmental and social impacts causing reputational damage		Likelihood	Consequence	Score
			Inherent	5	4	20
			Current	4	4	16
			Target	2	4	8

IMTP Deliverable Numbers: 17, 18, 33

Strategic Objective: 6b Commercial/Foundation Economy, Value-Based Healthcare & Environmental Sustainability

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

Risk Commentary

Challenges continue around resources and technology, and currently there is not an ability to reduce this score. Decarbonisation Programme Board continue to meet. Noting some progress on positive movement to actions within the DAP. Recent progress is focussing on implementation of PHEV and BEV SRVs. WG is refreshing the Strategic Delivery Plan – final version now received and discussion took place at ELT (25th February 2026) on the Trust response, the next steps, and the resources required to further progress this. It should be noted that as work in this space increases, so too does the volume of BAU management required e.g. on the development of EV charging infrastructure, the Trust now has an EV Network which needs to be formally managed (contract management with suppliers, remedial action on faults, warranty renewal, liaison with suppliers, use of network and prevention of fraudulent use, reporting on charging capacity used, financial implications etc). Actions will need to be updated following ELT discussion.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Oversight of implementation and delivery of Decarbonisation project and monitoring of action plan at Decarbonisation Programme Board and Capital Management Board	1. Regular meetings of the Decarbonisation Programme Board quarterly. Requirements of the Decarbonisation project have been presented to the Trust Board & Finance and Performance Committee. Challenges of the project have also been highlighted. Report goes regularly to FPC and then onto Trust Board. Next update will be January FPC meeting
2. Capital and Estates directorate lead support – Director of Finance (DOF)	2. Regular briefings to DOF
3. Partnership working via Communications/Stakeholder liaison group with NHS Wales, Welsh Government and other bodies to gain support and knowledge- with the anticipation of working in collaboration.	3. Sharing of knowledge via partnership working through various forums is documented in minutes of meetings held. Requirements also form part of the action plan
4. Approach changed for heating/lighting/energy systems to become more energy efficient- replacing old inefficient plant with more sustainable technology such as natural gas boilers for air source heat pumps	4. (i) Estate Survey undertaken every 5 years. This is a 6-facet survey to understand where the back log is and the requirements for energy systems. Next survey round to take place in 2025/26 which will inform the update of the Estates SOP. (ii) Approved Estates SOP (iii) Estate Retrofit Guide and framework used to prepare schemes
5. Changing procurement practices for fleet, Estates, equipment, supplies, and ICT to reduce emissions	5. Fleet SOP shows move to ULEV vehicles. BJC 2025/26 details intention for move to EV for smaller and support vehicles. Ambitions for further decarbonisation of fleet to be included in 2026/27 Business Justification Case (approved by Trust Board on 27th Nov and submitted to WG on 28th Nov 2025)
6. Board Development sessions with respect to Decarbonisation to raise awareness of decarbonisation requirements, additional sessions will be required.	6. Board Development session occurred on 8th November 2021 – presentation slides are available.
7. Finance & Performance Committee has oversight of decarbonisation project, decarbonisation to become a standard agenda item.	7. (i) Routine updates at every other FPC meeting (3 times a year) (ii) Annual report (which includes a Sustainability section) is approved by the Finance & Performance Committee
8. KPIs with respect to energy transmissions are communicated to Estates team annually by sustainability manager	8. KPIs to Estates team includes energy use at all WAST managed buildings
9. ISO14001 accreditation in place	9. ISO14001 – Annual audits are undertaken against the accreditation. Environmental Coordinators act as champions in the organisation.
10. Environment Strategy in place	10. Environment strategy has been approved by the Trust Board. This covers the next 5 years
11. Programme Board Risk Register	11. Programme Risk Register reviewed at every Decarbonisation Programme Board meeting
12. Reporting to WG via DCR reporting, qualitative, and quantitative reports and emissions reporting	12. Submissions to WG – quarterly DCR reporting. Annual qualitative and quantitative reporting
13. Membership of National Programme Board (WG), Transport Task and Finish Group and BELP Project Board	13. Minutes and papers of meeting
14. Full engagement in Strategic Development Plan (SDP) refresh process undertaken by Welsh Government	15. WAST specific comments provided. Full engagement in support of influencing future SDP (and therefore DAP) actions.
	External - Independent Assurance:

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	15/05/2026	TREND	16 (4x4)
		Date of Next Review:	15/06/2026	➡	

	• Sustainability section in Annual Report audited by Internal Audit. Annual audits by BSI on accreditation
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Establishment of further workstreams to address a Programme Plan to support strategy requirements	
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles	
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited)	
4. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost.	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles: develop an investment strategy/prioritised list of sites where further EV charging is required. Will need further investment.	Decarbonisation Programme Board	Ongoing programme of investment. Next phase to be complete by March 2026	Actions taken in line with investment provided to implement rapid charging by end of March 2025 at a small number of sites. Confirmed adequate charging provision for the replacement of 20 x PHEV and 10 x BEV in March/April 2025. This action is ongoing. Further consideration of the increasing resource requirements will be highlighted at the Transport Project Board, Decarbonisation Programme Board and through the Capital Management Board. Specific action in relation to development of investment plan was closed on the Audit Tracker in March 2025, given that this has been absorbed within other strategic investment plans. To note, as the Trust further implements infrastructure, there is a greater BAU workload which the team is currently not resourced to manage. With the development of EV charging infrastructure, the Trust now has an EV Network which needs to be formally managed (contract management with suppliers, remedial action on faults, warranty renewal, liaison with suppliers, use of network and prevention of fraudulent use, reporting on charging capacity used, financial implications etc)
2. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited): development of specifications for vehicles considering achievable and safe ULEV options where possible. NOTE: will be dependent on confirmation of 2024/25 BJC funding	Fleet Team	Ongoing programme of investment. Next phase to be completed by March 2026	Position remains that only vans can currently be purchased. This will be delivered by March/April 2025. Further PHEV SRVs and full BEV small NEPTS vehicles to be procured in 2025/26 for implementation by end March 2026.
3. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost: Development of an investment requirements schedule (also aligned to IA recommendations). Contribute resources to support the Decarbonisation Strategy action plan	Director of Finance & Corporate Resources	31.03.25 March 2026	Discussions ongoing regarding enhanced resource requirements to implement low carbon emission vehicles. Targeted Estate Fund (TEF) bids were submitted, and it has been confirmed that 3 of the 6 submitted projects have been supported. Work is well underway on delivery of the 2025/26 schemes. Further consideration will need to be given to the ELT discussion and actions arising on the Trust response to the new SDP, and the ability for the Trust to resource this appropriately. Given the developmental nature of this work, it is now not possible to sustain the current governance, infrastructure, progress without additional resource.

Risk ID 671	Unauthorised or Inappropriate use of AI technologies	Date of Review:	15/05/2026	TREND	16 (4x4)
		Date of Next Review:	15/06/2026	➡	

	Likelihood	Consequence	Score
Inherent	5	4	20
Current	4	4	16
Target	2	4	8

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 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 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, and non-compliance with other EU, UK or Welsh legislation, regulation and standards

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 is high due to the appetite of WAST to adopt new AI technologies, the ease of access by individuals to a breadth of (freely) available Generative-AI tools offered by tech start-ups and companies globally, and the currently limited guidance and regulation offered in this sector for health & care providers.

Given the evolving nature of AI technologies, it will not be possible to fully mitigate this risk. The consequences will remain, but with greater awareness, confidence and support for staff, the chance of breach, bias, or reputation damage from AI output can be reduced.

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

CONTROLS	ASSURANCES
1. Guidance & Awareness a) Gen-AI guidance + Engagement sessions (small audience) b) Procurement toolkit c) **Guidance for using Copilot for AAA reports (awaiting approval)**	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 2026**
2. Strategic Alignment a) IMTP reference to use cases	2. Strategic Alignment a) AI safety and adoption updates reported via Digital Report to Finance & Performance 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 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.	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)** b) Monitoring of Datix incidents related to data breaches and security

Risk ID 671	Unauthorised or Inappropriate use of AI technologies	Date of Review:	15/05/2026	TREND	16 (4x4)
		Date of Next Review:	15/06/2026	➡	

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 informally reported via IGSG to date in lieu of dedicated forum b) - c) First meeting of monthly AISG occurred in October 2025, with AAA to be shared at next meeting of IGSG, and routinely thereafter.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Guidance & Awareness a) Copilot rollout and chat requires guidance for all WAST staff b) General awareness sessions / e-learning for all WAST staff c) Ethics and responsible AI frameworks	1. Guidance & Awareness a) eLearning compliance b) Pulse check or other mechanism to understand staff views on AI c) Approval and monitoring of any developed or adopted frameworks by AISG and IGSG
2. Strategic Alignment a) AI Mission Statement / strategy b) Clear set of 'approved' use cases c) Steering Group to maintain alignment of use cases and horizon scan (for opportunity and risk)	2. Strategic Alignment a) Regular reporting and clear governance route from AI Steering Group to Board
3. Technical Controls a) MS 365 Copilot chat offer for all staff (without need for upgraded licence) - needs monitoring for appropriate use b) Sanctioned / unsanctioned apps list to be maintained c) Monitoring and auditing of users d) Sensitivity tagging 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 b)

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Publication of WAST AI Policy	Leanne Smith	~~November 2025~~ June 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 June 2026 meeting to allow inclusion of recent guidance and external policy updates.
2. Agreement on sanctioned and unsanctioned apps, and block of certain apps / sites	James Rowland	**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	To be managed by AISG
4. Board Development Day and AI Mission Statement development with Trust Board	Leanne Smith	~~February 2026~~ June 2026	Deferred to June 2026 Board Development Day due to recent absences of key individuals in Digital, and a scheduling conflict with the February BDD

Risk ID 671	Unauthorised or Inappropriate use of AI technologies	Date of Review:	15/05/2026	TREND	16 (4x4)
		Date of Next Review:	15/06/2026	➡	

5. Copilot rollout to avoid ChatGPT risk – requires usage monitoring mechanism	Aasha Cowey	June 2026 (current pilot licences run until this time)	Dependent on funding Dec-25: copilot pilot evaluation underway, and decision to be made on reallocation of unused licences and associated process. Mar-26: Copilot Chat – a version included already in core licencing arrangements is being explored as a more affordable way to rollout this technology for the majority of staff. **May-26: Copilot Chat has been rolled out by DHCW with supporting comms campaign. This is being supported internally by Comms team and AI Steering Group. Monitoring of usage by users is in progress.**
6. Alignment with WG and NHS Wales AI policy positions	Leanne Smith	Q4 25/26	Proactively engage with WG AI Commission March-26: NHS Wales AI commission is being redesigned. Engagement has not been able to progress.
7. eLearning for all staff	Leanne Smith	Q4 25/26	Supported by AISG Dec-25: AISG to support Digital Learning Manager (Education & Development team) in development of AI e-learning module. Leanne Smith as Chair of AISG to be responsible for updates on this action. March-26: AISG are reviewing an internally developed offer and will provide a recommendation to Board at the Board Development Day (as part of action 4)
8. IG x AI programme (confirming DPIA and checklists are appropriate)	Kelly Holding	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.
9. WG AI Commission membership / alignment	Leanne Smith	Q3 25/26	Proactively engage with WG and NHSW AI groups Dec-25: Welsh Government are redesigning the AI Commission and considering membership (likely to include Directors of Digital). An AI policy and plan is also in draft for Wales. Further updates are expected in Q4 25/26. Mar-26: no further updates have yet been received from across Wales.
10. 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.
11. AI Lead to be identified and agreed	Leanne Smith	Q3 25/26	AISG to have oversight

Risk ID 690	SAR and Disclosure of Records Compliance	Date of Review:	17/05/2026	TREND	16 (4x4)
		Date of Next Review:	17/06/2026	➡	

IF	THEN	RESULTING IN
records requests from patients, the public or staff are not processed consistently or correctly	inappropriate withholding of information or disclosures may occur	negative environmental and social impacts causing 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

January Personal Data Breach LFER: Safeguarding information disclosed within a SAR response has resulted in a claim of £9,311 and requires submission of a Learning from Events Report to Welsh Risk Pool, with scrutiny of evidence of improvements.

Compliance Review Outcomes (Records Requests Procedures): The review identified gaps and risk areas. Actions are detailed in the Records Improvement Plan, including SOP gaps and QA/approval routes requiring completion and monitoring.

Recent Complaints: Indicate ongoing concerns about records access and handling, reinforcing the need to formally capture this risk.

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.

May-26: given the risk of non-compliant processes, risk of additional data breaches, complaints, and significant pressure on the Records team which could result in mistakes and amplify the compliance risks, a "Records Recovery Taskforce" was established in April, with an 8-week timeline to improve the position of the SARs backlog, processes & operations, and the resilience and wellbeing of the team. This taskforce is responsible to the Information Governance Steering Group, and is providing regular updates to this forum, with onward cascade to Executive Leadership Team via a AAA report.

CONTROLS	ASSURANCES
	Internal Management (1st 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.
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.**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. DPO approved SOPs or policies for all Records Request types (e.g. SARs, Access to Health, police, coroner, and other internal and external requests)	1. Current review of all SOPs in process which will include statutory requirements.
2. Consistent letter templates.	**2. DPO approved standard wording is required across all responses for various record types.**
3. Quality Assurance processes	3. **Capacity to conduct QA for non-standard cases is extremely limited and often results in large backlogs sat with a single individual.**
4. Managing workloads to avoid deadline breaches.	4. Evidence of individual and team level training; **categorisation, prioritisation and processing approaches require review**.

Risk ID 690	SAR and Disclosure of Records Compliance	Date of Review:	17/05/2026	TREND	16 (4x4)
		Date of Next Review:	17/06/2026	➡	

5. Better tracking systems – manual tracking for the current increased workload is proving more difficult.	5. **Current spreadsheet tracker requires review or improvement, or migration to a more robust digital system.**
6. Inadequate training/knowledge in correct processing requirements.	6. **Targeted training sessions required.**

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**	**External contract support sought to support delivery of this action. 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. Other SOPs awaiting development and being addressed as part of the Records Recovery Taskforce.**
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**	**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.**
3. Deliver targeted training/briefings on SAR and appropriate data disclosure processes.	Head of Records (with DPO oversight)	~~March 2026~~ **June 2026**	**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**	**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.**

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:	12/05/2026	TREND	15 (3x5)
		Date of Next Review:	12/06/2026	➡	

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 Q1 2024/2025

The challenges across the unscheduled care system**.** Handover lost hours in **March were 16,648 and April 13,746.** There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital E.Ds. Several incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.

After a thorough review and assessment of Risk 594 within the Corporate Risk Register at SLT on 02/10/2024, we propose reducing the risk score from 20 to 15 (likelihood from 4 to 3) due to the following reasons:

· Mitigation/Controls have been Implemented: We have several controls measures that directly address the identified risk and are content we have exhausted all opportunities for additional controls. These controls are embedded within the corporate risk register.

· Immediate Release Protocol: The revised version of the IR protocol v1.3 has been agreed and shared at COO group and published which has included the release schedule for ambulances at the declaration of an incident as set out below:

·50% of vehicles released within 10 minutes

· 75% of vehicles released within 20 minutes

· 100% of vehicles released within 30 minutes

· Monitoring and Review: We will continue to monitor the risk within the normal governance channels (SOT/SLT/ADLT etc) to ensure that mitigations are still in place and any emerging risks are promptly identified and addressed.

22/01/25 - In light of the critical incident declared earlier this month, a review of the risk scoring is scheduled for this at SLT on 11th February in the first instance and this will be updated following conversations.

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

May 26 - Short of any testing or exercising we have exhausted all internal actions and therefore we accept the risk remains at a 15. 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

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:	12/05/2026	TREND	15 (3x5)
		Date of Next Review:	12/06/2026	➡	

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.
12. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration.	12. All Health Boards responded with assurance of plans except BCU.
13. Multi Agency Exercise to be arranged.	13. This exercise has taken place although Health Boards declined to incorporate vehicle release plans
14. Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.	14. WG have confirmed that they have written to HB EPRR leads. Health Board COOs approved the proposals for vehicle release as outlined.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.	The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.
	Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morriston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review of Manchester Arena Inquiry	Assistant Director of Operations	**CLOSED**	This programme of work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios. The financial case associated with MAI is planned to be familiarised with ELT and JCC during Jan and Feb 2024, with the final outline case to ELT in March 2024. A revised timeline for the governance process for the final MAI reports has been agreed, commencing in May 2024 and finalising at Trust Board the end of July 2024. 01/10/2024 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust continues. The Trust has undertaken a detailed review of its provision as part of its obligation under recommendations 105 and 106 and has recently produced an evidence-based series of reports aimed at addressing the identified gaps. This has been supported further by the development of three Quality Impact Assessments that have been approved by the Clinical Quality Governance Group. The work identified 20 recommendations for which there is a financial dependency. The submission to commissioners of the Trust's reports relating to these recommendations has now occurred and the Trust awaits their considered response. The remaining recommendations continue to be progressed, and it is anticipated these will conclude within the next six months. To ensure the continued visibility of these report findings within the Trust, a corporate risk is being developed for inclusion in the Trust's risk register. This will enable the alignment of outstanding MAI recommendations with a clearly defined business-as-usual framework, ensuring proper governance of

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

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:	20/03/2026	TREND	12 (3x4)
		Date of Next Review:	20/06/2026		

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.

CONTROLS	**ASSURANCES**
	Internal & External Management (1st Line of Assurance)
1. JCC/WAST Forward Plan for EMS and NEPTS in place and monitored at JCC meetings	1. Minutes of meetings and a standard agenda item
2. JCC and its 2 sub-committees established as a forum to discuss WAST's strategy	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.	1. 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	2. Minutes of meetings and a standard agenda item
	External Management (1st Line of Assurance) 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. JCC remit is wider than just ambulances and will reduce the agenda time dedicated to WAST's three patient pathways.	1. A shorter provider brief will go to the JCC with more detailed discussions taking place at its sub-committees. There is no provider brief going at this time, but the Trust does produce extensive slides for the bi-monthly WG Integrated Quality, Planning & Delivery accountability meeting, with the Director of Commissioning for Ambulance & 111 Services in attendance. 02/12/25 It is anticipated

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:	20/03/2026	TREND	12 (3x4)
		Date of Next Review:	20/06/2026	➡	

	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.
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.

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:	20/03/2026	TREND	12 (3x4)
		Date of Next Review:	20/06/2026	➡	

			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. 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

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:	20/03/2026	TREND	12 (3x4)
		Date of Next Review:	20/06/2026	➡	

			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:	13/05/2026	TREND ⬆	12 (3x4)
		Date of Next Review:	13/08/2026		

				Likelihood	Consequence	Score
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	**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 but with a target commencement date of Qtr. 2 of the 2026/27 financial year. WAST is currently seeing the continued impact of the increase in fuel prices 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.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at FPC, and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	
3. Budget management meetings	3. Diarised dates for budget management meetings and delegation of budgets
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 (1st Line of Assurance)
	5. Monthly Monitoring Returns to Welsh Government
	7. JCC management meetings and at bi-monthly meeting with JCC Finance teams
	8. Capital meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	13/05/2026	TREND	12 (3x4)
		Date of Next Review:	13/08/2026		
	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	~~31/03/26~~ 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	~~31/03/26~~ 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	~~31/03/26~~ 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	~~31/03/26~~ 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.