Bundle Reading Room 23 June 2026

9 Risk Management and Board Assurance Framework
Item 09 Annex 4 Board Assurance Framework

Annex 4 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	12/05/2026	TREND	OVERALL 25 (5x5)
		Date of Next Review:	12/06/2026	⬆	

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

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

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

Risk Appetite Level – Open

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

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

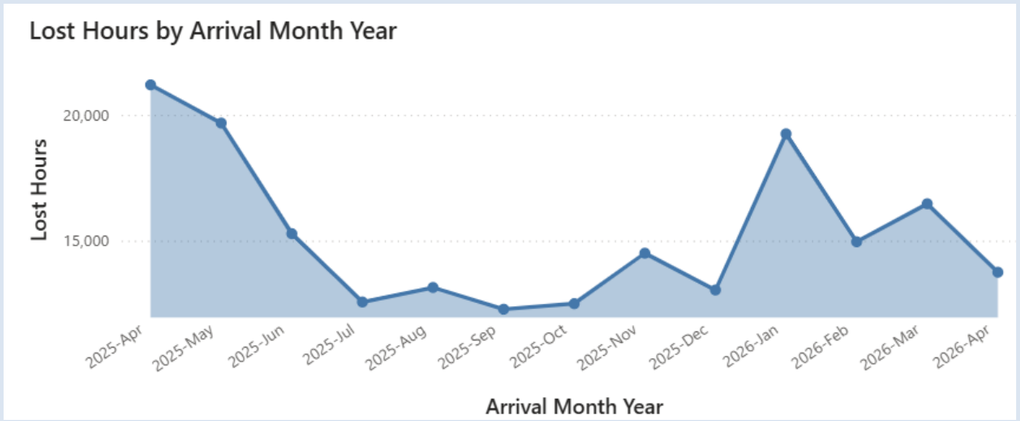
The next steps will include testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death.

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

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

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

Risk Commentary



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. In recent weeks, however, we have seen a deterioration in 45MR compliance in those areas such as Swansea Bay that had seen improvement previously and a recent increase in hospital delays is also representative of pressure across the secondary care system.

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

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through internal controls alone. However, increasing national scrutiny, greater transparency, and a shift toward more integrated, system-based accountability present a clear opportunity to improve consistency and collective impact across organisational boundaries.

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

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

The introduction of 45 Minute Release (45MR) from 1 October 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. In recent weeks we have seen a deterioration broadly in 45MR compliance in those areas that had seen improvement previously and a recent increase in hospital delays is also representative of pressure across the secondary care system.

10.02.2026 - This trajectory does not yet represent sustained deterioration; however absolute lost hour levels remain unacceptably high even when there has been short term improvement.

SLT recognises there has been a deterioration of 45MR compliance through December and January and on that basis, it is anticipated that there is a trajectory of re-escalation of the risk scoring. It is the intention of SLT therefore, as per previous reviews, to evidence a similar period of deterioration as we did in improvement before consideration of re-escalation of scoring.

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.

CONTROLS	ASSURANCES		
MONITOR – External	External ***Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.***		
1. External Handover Improvement Group (NHS Exec)	1. Established handover improvement group led by the Director of Operations, NHS Exec to address persistent delays in ambulance handovers at Emergency Departments. The groups' purpose is to coordinate improvement plans across Health Boards, monitor compliance with national guidance and facilitate audits and performance tracking through NHS Exec oversight. The introduction of 45 MR from 1 October and the efforts made by the majority of Health Boards in the proceeding months, is a welcome step. A clinically led Handover-45 taskforce has been formed and workshops hosted by the NHS Wales Performance and Improvement are ongoing to support local improvement plans.		
2. Welsh Health Circular	2. Setting national standards for 15-minute patient handover timeframe, clinical practice, quality governance and operational safety mandating actions like early warning score implementation and infection control whilst also embedding legal compliance through frameworks e.g. Duty of Quality. Outcomes are primarily overseen by the Welsh Government through a combination of national audit programmes and governance frameworks. The External Handover Improvement Group has been established consider the elements of the Welsh Health Circular.		
3. Mitigating Avoidable Harm Actions	3.. Actions were developed in direct response to persisting and escalating system pressures. The avoidable harm paper outlines a strategic framework to reduce patient risk with key measures including the clinical safety plan, Immediate release protocol and governance via the Serious Clinical Incident Forum (SCIF). Outcomes are monitored through risk scores, DATIX reporting, clinical audits and patient harm indicators. Actions were developed in direct response to persisting and escalating system pressures.		
4. Sustainability of 45 MR in Cardiff and Vale, Cwm Taf and Swansea Bay	4.Performance data confirms that Cwm Taff Morgannwg are consistently meeting the 45MR target. Ongoing regular performance reviews, and exception reporting will provide continued assurance that compliance will be maintained throughout the winter period.		
MITIGATE - Internal ***How do we know the controls are effective. How will these impact the target risk score?***	Internal ***over the three lines of assurance. How do we know the assurances are effective*** ***Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk***		
Control 1 – Policies/SOPs Regional Escalation Protocol, Immediate Release Protocol v.1.3 (Released August 2024), Resource Escalation Action Plan (REAP –	**First Line of Assurance** Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly Performance, Demand and	**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.

v5.1 released January 2025), Clinical Safety Plan (CSP – released December 2024)	Capacity meetings to review REAP levels.		
Control 2 – Performance/Tactics ETA Scripting, CCC Emergency Rule, Red call performance, Transfer of Care, ARA (Swansea and YGC), EMS Demand and Capacity Review.	**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. Local Business Meetings performance discussions.	**Second Line of Assurance** ETA dashboard, UHP reporting in local and business meetings. ODU dashboards, Performance Demand and Capacity performance metrics data, MIQPR (Monthly Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly).	**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 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.

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2. Operational pressures within Emergency Departments and inpatient areas continue to affect the ability of Health Boards to consistently adhere to the 15-minute handover expectation, despite the presence of national guidance. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.	2. There is limited independent scrutiny or assurance regarding how capacity pressures within Emergency Departments and inpatient settings are being addressed by Health Boards. These constraints directly affect handover performance but fall outside of WASTs operational control or influence. Limiting the Trust's ability to mitigate the risk independently. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.
3. Local Delivery Units limited to 2 Health Board Areas (Hywel Dda and BCU)	3. Inconsistency with the Local Delivery Units being implemented in only two Health Boards however recognising that the LDUs within Hywel Dda and BCU are in their infancy with potential rollout Pan Wales dependant on the success of the measurable outcomes.
4. Inconsistent pathways across Health Boards	4.
5. Local Delivery Units – Hywell Dda and BCU	5. A model to replicate oversight and scrutiny across Health Boards, like the Trust's Operational Delivery Unit (ODU). Activity will be based on the System Escalation Framework actions complemented by Local Action Plans – Date of implementation of LDUs to be confirmed. Moved from Control to Gap in control - SLT will be content to move to control upon completion of implementation of LDUs.
6. Ministerial Advisory Group (MAG)	6.Providing independent oversight of NHS Wales performance and recommending standardise clinical pathways to reduce delays and improve outcomes. MAG promotes better use of data to monitor patient safety, while its recommendations are embedded into national risk frameworks and Board Assurance processes to ensure system-wide impact. Moved to Gap currently - only 1 meeting has taken place so far. SLT content to move to control once meetings are fully established
Internal	Internal
1. Clinical Model Transformation (CMT) not fully implemented	1. Due to the implementation not being fully established there may be gaps in assurance meaning limited evidence currently or certainty that the controls are working as intended, however, as the model progresses the measurable outcomes will be reviewed and any concerns/issues addressed and monitored through actions. Current methods of monitoring the CMT includes CMT Project Board and an approved governance, reporting structure through T&F Groups.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner (Internal only)	Completion / Milestone date	Progress Update
1. 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**
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.** **22.05.26 Work is ongoing with SBUHB, ABUHB and BCU.**

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:	15/05/2026	TREND	OVERALL 25 (5x5)
		Date of Next Review:	15/06/2026	→	

IF	THEN	RESULTING IN
patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	patients coming to significant harm and a poor patient experience

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

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

A different approach to the Trust's highest scoring risks in a way that describes the internal and external controls, assurances and gaps which have been separated into those that the Trust manages and those that it monitors has been embedded.

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

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

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

Risk Appetite Level – Open

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

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

This risk remains at the highest level. **Although improvement has been demonstrated intermittently in some areas**, performance remains variable across Wales and **prolonged** handover delays continue to present a significant risk of delayed access to definitive care, 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.

Continued engagement with national and regional programmes, including Six Goals and Wait 45, remains essential to support improvement. **Recent deterioration in handover lost hours and variable compliance with 45 Minute Release standards continue to impact system resilience and ambulance availability**. Until sustained and evidenced system-wide improvement is demonstrated, the risk remains above target and appropriately sits on the Board Assurance Framework.

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.** 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.	1. **External Monitoring / Assurance** • Oversight through Welsh Government, including Six Goals and Joint Commissioning arrangements. • Independent scrutiny via national audit and regulatory inspection.

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:	15/05/2026	TREND	OVERALL 25 (5x5)
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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.
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,	**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.

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.			
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, resulting in variable confidence in system-wide impact.
2. Ongoing Emergency Department and inpatient capacity pressures limit consistent delivery of national handover standards by Health Boards.	2. Limited independent assurance on how Health Boards are addressing Emergency Department and inpatient capacity pressures that impact ambulance handover performance.
Internal	Internal
1. Limited ability to independently validate the effectiveness of Health Board actions arising from handover-related harm cases shared by WAST.	1. Routine audit of patient deterioration and management during delayed handovers is not yet embedded across all sites, limiting the ability to quantify the full scale of harm and test the effectiveness of mitigation
2.	2. Limited independent assurance on the effectiveness of Health Board actions arising from joint investigations into delayed handover harm; assurance is largely reliant on Health Board feedback. This gap may be strengthened through Audit Wales and MAG oversight.

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:	15/05/2026	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. Contribution to the development of a national joint investigation learning repository	Assistant Director of PTR	Q1 2026	Pilot completed with Cardiff and Vale UHB. Evaluation concluded (Sept 2025). National roll-out agreed and to be progressed through the Once for Wales Concerns Management Programme.
2. Delivery and evaluation of the Clinical Model Transformation (CMT)	Assistant Director of Operations, Integrated Care	Q2 2026	Phase 1 go-live completed (July 2025). Phase 2 go-live completed (November 2025). Public communications issued. Programme delivery and evaluation ongoing. Impact on handover risk to be assessed through programme evaluation and system performance data.
3. Audit Wales review of the urgent and emergency care system	Executive Director of Operations	May 2025 (report received); implementation ongoing	Audit Wales recommendations are being taken forward through agreed system and Trust governance arrangements, with delivery led by the Executive Director of Operations and oversight through ELT and the Board.

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 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.

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

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

Risk ID 641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Date of Review:	12/05/2026	TREND	20 (4x5)
		Date of Next Review:	12/06/2026	➡	

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:	22/05/2026	TREND	16 (4x4)
			Date of Next Review:	22/06/2026	➡	

IF	THEN	RESULTING IN
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	there will be a lack of stakeholder confidence in our ability to delivery our strategic objectives and system wide goals	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. ***There is clearly a greater focus by the new Government on performance which could represent a risk.*** 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
4. Strategic Engagement Framework in place	2. Focus on IMTP priorities that require stakeholder engagement (e.g. commercial partnerships, academic partnerships and LTS)
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**
2. Operational/Executive consistency of messaging	3. No consistent way of gathering information in consistent stakeholder engagement – this gap is unlikely to be easily closed.
4. Reliance on individual relationships rather than formalised frameworks	3. This gap is unlikely to be easily closed as the continuity and trust is lost if individuals move on
5. Limited formal evaluation of stakeholder confidence levels	4. 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
6. Financial savings may result in reputational risk	5. 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	
3. Managing political environment and any changes resulting from this	DoP&E	Routine BAU	Sharpened focus due to this being an election year

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.

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	➡	

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

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

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

	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 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 680	Failure to prioritise people capability and organisational culture could result in deteriorating Employee Experience, reduced wellbeing and absence	Date of Review:	07/05/26	TREND	16 (4x4)
		Date of Next Review:	07/06/26	➡	

IF	THEN	RESULTING IN
insufficient focus on people capability and organisational culture	will lead to a poor employee experience, low morale, burnout, fatigue, reduced wellbeing and increased sickness absence	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

This risk remains significant due to ongoing pressures affecting employee experience, wellbeing, and overall workforce capacity. The current score reflects the combined impact of sustained organisational strain, increasing service demand and the variability in leadership capacity, cultural practices, and people process consistency across the organisation. Together these factors continue to influence morale, sickness absence and the Trust's ability to maintain safe and effective service delivery. Although a broad set of controls in in place – such as leadership development, cultural improvement activity, wellbeing support, strengthened people processes, and mechanisms that encourage staff voice – their maturity and consistency vary across services, meaning the overall risk remains above tolerance. While many teams benefit from supportive local cultures and effective management practice, others continue to experience challenges linked to workload, change fatigue and uneven access to development or limited confidence in speaking up or raising concerns.

The programme of work underway aims to improve consistency, strengthen leadership behaviours, enhance visibility or culture and capacity pressures and modernise people processes. Initiatives focusing on compassionate leadership, improving the quality of conversations, embedding organisational values, strengthening recruitment approaches, and promoting psychological safety are expected to improve assurance overt 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. Working Well Together (CEWS)	Deployment of cultural reviews, listening exercises and team development where early issues are identified, or where teams experience conflict, high sickness or declining morale. CEWS used as an internal, team-level diagnostic to spot early cultural risks, stressors, fatigue indicators or team dysfunction. Team-level monitoring of CEWS status and progress against agreed co-created actions, with periodic internal reporting to relevant Heads of Service or Senior Leadership Teams on interventions, themes and improvements *CEWS deployment across teams generates measurable indicators of cultural risk, conflict, fatigue and team functioning. Internal reports summarise findings, interventions, and improvements, providing assurance that emerging risks are identified early and acted upon. Heads of Service oversight ensures accountability for local action.*
2. PADR	Strengthening the quality of PADR conversations, with explicit focus on wellbeing, workload, personal development and local team culture. Manager guidance and development to improve the depth, openness and value of PADR conversations. Monitor PADR quality through staff survey feedback rather than compliance-only measures. *Assurance drawn from staff survey metrics, thematic evaluation of PADR quality, and feedback mechanisms assessing depth and value of wellbeing-focused discussions. Regular monitoring reports highlight improvements, variability, and targeted support needs to strengthen consistency.*
3. Culture Champions Network	Active Culture Champions network providing local visibility of Our WAST Way, supporting wellbeing and encouraging open, safe conversations. Champions act as early eyes and ears for cultural concerns and promote supportive behaviours. Ongoing development sessions strengthen Champion capability and provide a two-way mechanism for feedback, enabling concerns and opportunities for improvement to be surfaced. *Regular activity reports from the Culture Champions network provide assurance of local cultural insight, early escalation of concerns, and the effectiveness of peer-led cultural interventions. Feedback loops demonstrate that insights are acted upon by senior leaders.*
4. Speaking Up Safely Process	Ensure all staff are confident speaking up to line managers and where this is not possible are confident using the speaking up safely pathways. Speaking Up Safely data, themes and case handling outcomes provide assurance on psychological safety and accessibility of speaking-up pathways. Trends and thematic analysis are reviewed regularly to ensure issues are addressed and escalated appropriately.

Risk ID 680	Failure to prioritise people capability and organisational culture could result in deteriorating Employee Experience, reduced wellbeing and absence	Date of Review:	07/05/26	TREND	16 (4x4)
		Date of Next Review:	07/06/26	➡	

5. Improving Working Environment	Seek opportunities to improve the working environment, including where and how people work including flexible working opportunities. Feedback from staff engagement activity, data on flexible working, and local team action plans provide assurance that environmental issues are identified and mitigated, with tangible improvements monitored over time.
6. Improving Wellbeing	Sustain a focus on improving the wellbeing of staff through implementing the Health and Wellbeing Plan predominantly led by the Occupational Health and Wellbeing Department supported by various health and wellbeing initiatives including access to internal and external support, TRiM and targeted workshops (Suicide Risk Training etc.). Assurance derived from the implementation progress of the Health & Wellbeing Plan, utilisation of wellbeing services, TRiM activity monitoring, and thematic insights from support interventions. Regular reports demonstrate effectiveness and identify gaps.
7. 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.
8. Fairness and Equality	Encouraging inclusive practices to ensure that people who may face additional challenges or discrimination due to a protected characteristic or vulnerability are supported at work and have the opportunity to explore reasonable adjustment to support them in the workplace
9. People Networks	Range of wellbeing support provided to staff via our people networks. This includes safe space conversations, input into Trust programmes to ensure that they are inclusive, staff initiatives to reduce inequalities, and expert advice and support from external organisations and training providers. This is provided alongside a range of staff benefits and wellbeing support such as financial wellbeing, physical and mental health wellbeing activities available to our workforce. **Completed actions:** • **Update 06/05/26: Disability Confidence status renewed**
CAPACITY	
1. Workforce Capacity Pressures	<u>Completed actions:</u> • Update 09/03/26: OCP Detailed documentation and process flow chart created.
2. Improving Internal People Processes	Focus on getting the basics right by improving the effectiveness and application of internal people processes. Process performance indicators, audit outcomes, and compliance monitoring provide assurance of improvements in the effectiveness and consistency of internal people processes. Completed actions: • Update 09/03/26: Collectively defined and agreed programme deliverables at the People Services Away Day end of Jan. Programme deliverables mapped.
3. 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, allyship and active bystander training. Recruitment metrics, diversity data, and evaluation of targeted outreach or allyship programmes provide assurance that workforce diversity and equity targets are progressing. Reports highlight trends, risks and areas requiring further focus.
4. 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. Ensuring managers are familiar with and comfortable using the policy and processes.
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 <u>Completed actions:</u> • Update 09/03/26: 2 x accredited Change Management courses scheduled for March, training a further 24 colleagues.

Risk ID 680	Failure to prioritise people capability and organisational culture could result in deteriorating Employee Experience, reduced wellbeing and absence	Date of Review:	07/05/26	TREND	16 (4x4)
		Date of Next Review:	07/06/26	➡	

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. Provide periodic summary reports to stakeholders on leadership development activity, participation and impact. *Evidence of compassionate leadership behaviours demonstrated through staff survey indicators, feedback from leadership development activity, and quality insights from Essential Conversations and routine check-ins. Regular reports to People & Culture Committee provide assurance on consistency, behavioural alignment, and leadership practice maturity.*
3. Improving Digital Capability	Enhance digital capability and improve the digital experience for all staff. Digital capability assessments, usage analytics, and training evaluations provide assurance that digital development activities are improving confidence and capability across the workforce.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
CULTURE	
Working Well Together (CEWS)	Although tools such as CEWS, cultural reviews and team development interventions exist, their deployment it uneven resulting in: • Some teams receiving early cultural support while others do not. • Limited visibility of cultural risks in areas not routinely engaging with CEWS or development support. • Variable leadership confidence in recognising cultural deterioration early.
PADR	Inconsistent application of compassionate practices, Essential Conversations, routine check-ins and Crucial Conversations across leadership levels, alongside variation in the quality of PADR conversations. Managers demonstrate inconsistent capability in conducting meaningful wellbeing-focused discussions, and PADR continues to be perceived in some areas as a compliance exercise rather than a valuable developmental conversation.
Culture Champions	The Culture Champions network is active, but: • The consistency of Champion engagement varies across geographical areas and departments. • There is no fully standardised mechanism for monitoring Champion activity, reach, or outcomes. • Insight generated locally does not always feed systematically into strategic decision-making.
Speaking Up Safely	While the Speaking Up Safely process exists, there are ongoing gaps in: • Confidence across all staff groups to use the process, especially in operational and hierarchical environments. • Manager capability to create psychologically safe, blame-free team climates where local speaking-up is normalised. • Consistency of feedback loops ensuring staff understand how concerns are acted upon.
Improving Wellbeing	Insufficient capacity to bridge any identified gaps.
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.
Fairness and Equality	Difficult to release staff, particularly from operational duties, to attend training to broaden understanding of the challenges faced by those with a protected characteristic or a vulnerability.
People Networks	Capacity to have meaningful engagement with Network Members, alongside work commitments.
CAPACITY	
Insufficient Visibility of Workforce Capacity Pressures	• No real-time, systematic way to surface local capacity pressures early (e.g., workload imbalance, chronic understaffing, high demand on specific roles). • Variation in leaders' ability to recognise capacity-related risks across dispersed teams
Inconsistent application of people processes across departments	Although improving internal processes is a priority: • Line managers apply processes differently depending on experience, workload, or interpretation. • Inconsistent compliance and quality reduce the ability to ensure fair, timely, and effective decision-making.
Recruitment and Attraction Interventions not fully embedded	While recruitment plans exist: • Targeted approaches (e.g., outreach, allyship-driven recruitment) are not consistently adopted.

Risk ID 680	Failure to prioritise people capability and organisational culture could result in deteriorating Employee Experience, reduced wellbeing and absence	Date of Review:	07/05/26	TREND	16 (4x4)
		Date of Next Review:	07/06/26	➡	

	• 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.
Digital Capability not consistently developed across the Workforce	Despite digital training and assessments: • Some roles lack protected time to undertake digital development. • Digital literacy remains variable, particularly in remote, operational, and non-desk-based roles. • No organisation-wide baseline for digital competence exists, creating inconsistency in expectations.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner (Internal only)	Completion / Milestone date	Progress Update
CULTURE			
CEWS / Cultural Toolkit 1. Increase awareness and meaningful use of the CEWS tool.	Head of Culture & OD	• Launch refreshed CEWS Tool by end of Q1 2026/27	• Update 09/03/26: Refreshed CEWS tool and supporting guidance are being finalised for relaunch by the end of Q1. • **Update 05/05/26: Preparatory work to support the launch of the refreshed CEWS tool is underway, including embedding CEWS within the Working Well Together framework and developing clear guidance and operating arrangements to support managers.**
PADR 1. Strengthen accountability by setting clear expectations for leaders on compassionate leadership behaviours, Essential Conversations, and high-quality PADR discussions, reinforced through visible role-modelling from senior leaders. 2. Provide short, focused guidance and refresher support for managers on conducting meaningful wellbeing-focused conversations (inc. PADR), ensuring leaders feel confident and equipped.	Head of Culture & OD	• Pilot by end of Q1 2026/27 • Pilot Evaluation by end of Q2 2026/27 • Full rollout of refreshed process (including comms, training and resources) by end of Q3 2026/27	• Update 09/03/26: Preparation underway to begin pilot in Q1, Socialisation on new approach complete, and pilot teams identified. • **Update 05/05/26: Pilot has commenced, supported by manager and employee guidance, tools and scheduled drop-in sessions. Feedback mechanisms are live, and early learning is being captured to shape evaluation and next phase refinements.**
Culture Champion Network	Head of Culture & OD	• Encourage active participation through effective comms with Champion Network by end of Q2 2026/27 • Identify mechanism for sharing insights across the Trust by end Q2 2026/27	• Update 09/03/26: Culture Champions audit underway to identify areas/teams of low representation. Work underway to refine the Culture Champion role.

Risk ID 680	Failure to prioritise people capability and organisational culture could result in deteriorating Employee Experience, reduced wellbeing and absence	Date of Review:	07/05/26	TREND	16 (4x4)
		Date of Next Review:	07/06/26	➡	

			• **Update 05/05/26: Audit of Culture Champions membership is underway, alongside agreement of refreshed role expectations aligned to Our WAST Way and civility, to strengthen participation in the network.**
Speaking Up Safely 1. Increase awareness and understanding of a Speaking Up Safely culture. 2. Implement a detriment risk assessment and increase understanding regarding detriment following speaking up.	Lead Guardian	• Detriment Mitigation Tool end of Q3 2026/27 • SUS Booklets by end of Q1 2026/27	• Update 09/03/26: Detriment Risk Assessment renamed to 'Detriment Mitigation Tool' to better reflect its purpose and to move away from the perception that risk is defined solely by numerical scoring. The tool has now entered the pilot phase and is being applied to all new cases received by SUS. SUS information booklets are nearing completion at the design stage. • **Update 05/05/26: Pilot Phase commenced with Detriment Mitigation Tool being applied to all new cases. SUS Booklets have been designed and developed. Awaiting delivery of the product.**
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. 2. Launch the Health & Wellbeing to support personalised wellbeing conversations and reasonable adjustments with long term health conditions	Occupational Health Manager and Head of Workplace Wellbeing Head of Engagement & Inclusion	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 Health & Wellbeing Passport • Launch Health & Wellbeing Passport by end of Q1 2026/27	Update 09/03/26: • Stress Management: Digital Risk Assessment Tool in development, on track for completion for end of Q1. DPIA to be completed. Policy development has concluded and is going through consultation. EQIA to be undertaken. On track for full launch by end of Q3. • Health & Wellbeing Passport: Pilot underway, on track for launch by end of Q1. **Update 05/05/26:** • **Stress Management: Digital Risk Assessment Tool finalised, with next steps for testing which will be done in line with the Stress Management Policy throughout Q2. Policy in development and scheduled to go to Policy Group in September 2026.*** • **Health & Wellbeing Passport: Due to launch on the 1st June. Communication Plan developed to support the launch.**
Staff Survey programme of work 1. Increase engagement and response rates through targeted interventions, ensuring all colleague voices are heard, and effectively use data to drive informed decisions and actionable insights	Head of Change & Insights	• Analyse 2025 results by end of Q4 2025/26 - Complete • Publish organisational results for 2025 survey by end of Q1 2026/27 • Preparations and running of 2026 survey by end of Q3 2026/27 • Analyse 2026 results by end of Q4 2026/27	• Update 09/03/26: 2025 data analysis continues, with further detail will be shared with ELT and Trust Board at the end of March. • **Update 05/05/26: Organisational results have been analysed, with 2 facilitated workshops held with ELT and WASPT. Data shared with PCC. Directorate level data to be issued early May. Preparations to commence for launch of 2026 Staff Survey.**
Fairness and Equality 1. Review current training provision and explore options to develop online modular programme to encourage more uptake from operational staff who will be able to access the training remotely at a more convenient time.	Head of Engagement & Inclusion	• Review attendance and feedback from 2025-2026 in Q1 • Liaise with Culture Change Teams to explore options to develop online modular learning platform Q2 • Develop pilot modules for trial with operational teams Q3 • Review Pilot before project expansion Q4	• Update 09/03/26: Started to gather and analyse feedback in preparation for the SEP Annual Report. A summary will be published in the report. Pilot module development to commence in Q1.
People Networks 1. Explore options for partnership working with 3rd sector organisations who can provide support to staff at a reduced cost. Encourage people network members to adopt a local coordinator role and arrange for participation in more localised events which	Head of Engagement & Inclusion	• Review of people network governance to identify more Co-Chair support and review yearly plans Q1 • Carer Confident Level 2 application Q1 • Gold ERS Award submission Q1 • Source funding for partnership working to develop people networks Q1	Update 09/03/26: • People Networks: Review of network governance underway and meetings scheduled to identify gaps and further support required. Exploring opportunities to hold a people network training conference to increase skills of Chairs and Co-Chairs. • Carer Confident: Application drafted • Gold ERS Award: Application submitted. Awaiting outcome.

Risk ID 680	Failure to prioritise people capability and organisational culture could result in deteriorating Employee Experience, reduced wellbeing and absence	Date of Review:	07/05/26	TREND	16 (4x4)
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aim to connect people with lived experience and improve health and wellbeing.		• Summer Pride events to use local staff as volunteer coordinators Q2 • Link in with North Wales 3rd sector organisations to encourage more network activity in North Wales Q3 • Review network activity throughout 2026-2027 and budget for 2027-2028 Q4	**Update 05/05/26:** • **People Networks: Roles of Chairs and Co-Chairs are being developed.** • **Carer Confident: Application developed, will be submitted following review.** • **Gold ERS Award: Awaiting outcome, decision board on 3rd June 2026.**
CAPACITY			
Insufficient Visibility of Workforce Capacity Pressures 1. Better use of CEWS where P&C and Teams have identified where this would be good use 2. Embed enhanced OCP guidance documents 3. Pilot Heat Map to change activity across the Organisational by directorate	1. Head of Culture & OD 2. Head of People Services 3. Head of Change & Insights	• CEWS by end of Q2 2026/27 • OCP Guidance by end of Q4 2025/26 • Heat Map by end of Q2 2026/27	Update 09/03/26: • CEWS: Preparations underway for launch. Further socialisation of Working Well Together will take place during Q1. • OCP: Launching on 1st April 2026. **Update 05/05/26:** • **CEWS: Preparatory work to support the launch of the refreshed CEWS tool is underway.** • **OCP: Revised OCP process signed off and piloted from 11 May with initial OCP submission form, toolkit and guides on Siren to support a more rounded and collaborative approach to delivering OCP's at WAST.**
Inconsistent application of people processes across departments 1. Brilliant Basics Programme: Establish a structured programme of work designed to build a robust foundation for People Services processes and procedures. This initiative will focus on standardising and streamlining core activities to ensure consistency, efficiency, and clarity to colleagues, whilst reducing administrative burden.	Head of People Services	• Define Programme by end of Q4 2025/26 - Complete • Foundation Phase by end of Q4 2026/27	• Update 09/03/26: On track for programme to commence 1 April 2026. • **Update 05/05/26: Programme priorities and deliverables drafted with final review session scheduled end of May. Some deliverables already commenced to strengthen ways of working such as Monthly PS/Safeguarding meeting to deep dive cases etc.**
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 Q1 2026/27 • First Draft Document by end of Q3 2026/27 • Approval & Publication by end of Q4 2026/27	• Update 09/03/26: Undertaking engagement with Recruiting Managers across EMS, Integrated Care and Corporate areas, creating process maps and interviewing managers to understand what recruitment currently looks like for them and discussing areas of frustration and ideas. Comparative conversations with the SWAST recruitment team and some academic and industry research on recruitment strategies and models. Engagement is still on course to complete as planned. • **Update 05/05/26: Initial proposals, scope and approach have been developed, feedback being collated with stakeholders**
Lack of Proactive Controls to Address Attendance Variation 1. Continuation of proactive People Services / Occupational Team support to reduce sickness absence	Deputy Director(s) of People & Culture	• From Feb-26 the Occupational Health & Wellbeing Team will move into the People Services Team which will result in a Multi-disciplinary Team approach to holistic absence support to managers and employees by end of Q3.	• Update 09/03/26: OH&WB successfully moved into PS in Feb-26. Plan for Mar-26 to review OH&WB priorities and data • **Update 05/05/26:** o **Greater visibility and recording of the data between teams (OH/Wellbeing & PS) to enable earlier identification of sickness trends/hotspots** o ***Digital Risk Assessment Tool finalised, with next steps for testing which will be done in line with the Stress Management**

Risk ID 680	Failure to prioritise people capability and organisational culture could result in deteriorating Employee Experience, reduced wellbeing and absence	Date of Review:	07/05/26	TREND	16 (4x4)
		Date of Next Review:	07/06/26	➡	

			Policy throughout Q2. Policy in development and scheduled to go to Policy Group in September 2026Wellbeing commenced implementation of team consultations to understand root cause and common themes of high absence rates within specific localities and provide personalised team interventions. o **Review of current TRiM processes to avoid delay in assessment of Trauma related symptoms by implementing electronic self-referral form.** o **Scoping a proactive solution for trauma , stress and anxiety related intervention**
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	• Accredited Change Management Training to SROs by end of Q4 2025/26 – Complete. • 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 09/03/26: Change Decision Tool created and shared with key stakeholders for review and comment. 1-1s with Change Leads continues, seeking to understand progress to date, current challenges and changes planned over the next 12 months for each CMT workstream. Draft role profiles for SROs and Exec Sponsors shared with key stakeholders for review and comment.
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	• Engagement & Prioritisation with Phase 2 Design by end of Q1 2026/27 • 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 09/03/26: Phase 2 Engagement complete, proposals endorsed by ELT. Priority elements for delivery in 2026/27 have been identified and costed. Phase 2 Delivery Plan and Communication Plan in development. • **Update 05/05/26: Phase 2 scope has been refined in line with financial constraints and agreed with ELT, with delivery now set out in the 2026/27 plan. External partners are confirmed, First Line Leader programme development is underway, and planning for the Leadership Community and Our WAST Way Leadership Conference has commenced.**

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

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)
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			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 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	06/05/2026	TREND	12 (4x3)
		Date of Next Review:	06/08/2026	➡	

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

A tailored bespoke development programme for managers and Trade Union Partners at all levels has been delivered with further training and activities developed for first line managers for delivery in April and June 2026. The programme of engagement and relationship building will continue. Work continues on improving partnership working through the delivery of the action plan. The engagement structures below WASPT are in place and running. The Deputy Director of People and Head of Culture and OD have delivered workshop sessions for TU partners and managers across the organisation in senior and local roles. Personal relationships with TUPs are generally very good. At a local level there are ongoing discussions on a range of organisational change issues and currently engagement and partnership working is consistent but with an increased degree of tension as there have been difficult issues to discuss, in part driven by the financial challenges. However, conversations and engagement continue as talking is paramount and for this review the score has been 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. On a national level, TUPs have not confirmed acceptance of the 2026 pay offer of 3.3% and there is a risk for industrial action with one union having undertaken a consultative ballot with an outcome that members would support action.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
Agreed (Refreshed) TU Facilities Agreement developed in partnership	Agreed document which states governance arrangements and the criteria for time off for TU activity etc.
Go Together Go Far (GTGF) statement and CEO/TU Partners statement	Both parties refer to the documents and are signed up/committed to it
Trade Union representation at Trust Board, Committees	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
Monthly Informal Lead TU representatives and Chief Executive meetings	Diarised meetings
TU partners in Task & Finish and Project Groups	Good attendance and commitment are observed at the meetings. TU partners listed as members in terms of reference
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	Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings
Quarterly Report on TU activity to People and Culture Committee	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.
Ongoing project plan in place to support the improvement in relationships based on the ACAS report from 2022 updated and reported to WASPT	Development of mentoring and training opportunities for TUPs to support their roles.
AAA report of formal Partnership Forum (WASPT) reported to PCC or Board in future (return to BAU).	Training for managers and TUPs delivered
AAA from SLT Partnership Forum and Corporate Partnership Forum reported to WASPT	Stability in senior TU team
Externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree. Completed	Action plan developed and shared with TUPs. Implementation underway. A series of partnership working sessions (5) have been delivered to around 120 colleagues – managers and TU partners. Feedback from the sessions was captured and next steps were reviewed. Completed There is an ACAS action plan which is a live doc and is reported to WASPT to update progress.
Rhythm of meetings to curate and focus on relationships	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.

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	06/05/2026	TREND	12 (4x3)
		Date of Next Review:	06/08/2026		

Increased mutual respect and TU partner understanding and appreciation of challenges and pressures facing the Trust	
Rollout of partnership training across WAST now to be extended to first line managers	Four Social Partnership training days are scheduled for April and June with capacity for 80 colleagues per session. **Complete: Three Social Partnership training days delivered, with last due in June. Initial positive feedback from attendees and good engagement by TUP.**
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.	
Consider how we celebrate success and capture the positive learning	Captured as part of social partnership conference and subsequent comms But BAU in terms of partnership approach
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: Email to TUPs from Director of Strategy and Planning. Meetings completed business case in development for feedback to ELT
Output from Conference informing next steps in developing maturity of relationship	**Under review, gathering feedback from delivered Social Partnership training days**
Learning and Development opportunities for TU partners e.g. shadowing, digital skills, coaching and mentoring, EDI and Speaking up Safely	Complete: 15/01/26: Online learning on 365 published and advertised via Siren. This is now BAU.
Develop consultation guidance for managers	Complete: 15/01/26: This has been incorporated into the OCP guidance and updated to SharePoint in September.
Produce a report for ELT with a range of options on Skills Mix	Complete: 15/01/26: 3rd 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:
Refresh of engagement programme post Industrial Action and establish work	Deputy Director of People	Q2 2025/26 Revised date Q4-Q1 (26/27)	Plan agreed and being monitored via WASPT. The plan is dynamic with actions being completed and additional actions added to the plan as they arise. Draft training development underway in partnership with TUPs – list of training needs shared from TUPs. Completed Principles on engagement being developed (in part from the training) and as a result the partnership statement will be updated. eLearning courses created by WG Social Partnership Team to be added to Learn365 Further session of partnership training to be scheduled in Q2 2025/6 Development of learning events for first line managers including content in Our WAST Way Task and Finish group to develop a partnership development day for first line managers has been re-established and work is underway. Update 15/01/26: Provisional dates in March and April for session for first line managers. Update 10/03/26 Four sessions booked across Wales and bookings from managers and TU partners being taken. Schedule of the day agreed and sessions developed. 3 sessions in April and one in June 2026 **Update 05/05/2026 Three Social Partnership training days delivered, with last due in June. Initial positive feedback from attendees and good engagement by TUP.**
TU Partner development in key areas of EDI, Speaking up Safely and Safeguarding.	Deputy Director of People	Q4 2026/27	Update 10/03/26: A need to offer development to TUPs in key areas of EDI, Speaking Up Safely and Safeguarding have been identified. EDI courses available will be promoted through TUP groups. Speaking Up Safely training is being developed and Safeguarding training opportunities will also be presented later in 2026/27. **Update 05/05/2026 currently considering approach in line with identified teams to support delivery of offer.**

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)
	1-10 Internal audit reviews covering

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 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.