AGENDA ITEM No	11
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	4

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Trust Board
DATE	30th March 2023
EXECUTIVE	Trish Mills, Board Secretary
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EXECUTIVE SUMMARY

1. At the Board meeting on 26th January 2023 the Chair of the Audit Committee sought further clarity on the roles and responsibilities for risk management within the existing framework, in particular the role of the Executives, the Committees and the Board with respect to the higher rated risks. The Audit Committee then received a report at its meeting on the 2nd March 2023 which provided assurances in respect of the management of the Trust's principal risks, an overview of the current risk management framework with particular focus on assurance to Committees and the Board, and detail of the risk programme for the Integrated Medium Term Plan (IMTP) 2023-26.

2. The IMTP 2023-26 includes the elements that comprise the Risk Framework, including the Risk Policy, Procedures and Guidance, as well as training and education. In addition, it includes the development of a Board Assurance Framework (BAF) that reflects more closely the Trust's strategic objectives against its long term strategy – Delivering Excellence: Vision 2030.

3. A summary of the principal risks is set out in Annex 1 with a detailed description contained within the BAF in Annex 2. The risk review schedule and governance routes agreed by the Audit Committee have been delayed due to operational pressures including industrial action, as well as absence in the Corporate Governance team. A programme of work has since been established to ensure all 16 principal risks are formally reviewed prior to the May 2023 Board.

4. The 4 highest scoring risks,223, 224, 160 and 201 have been reviewed in full and mitigating actions updated as at 22nd March 2023.

5. The BAF focusses on the principal risks that are mapped to the Integrated Medium Term Plan deliverables and which might compromise the achievement of the Trust's strategic objectives. Until such time as the Trust transitions to a more mature and strategic BAF during 2023/24 as part of the risk transformational programme, these principal risks are the drawn directly from the corporate risk register.

6. The BAF provides the Board with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings.

7. The gaps in controls and assurance are set out on the BAF, as are the actions planned to address any gaps. This detail provides Members with an insight into the planned activity, as much as can be anticipated from time to time, to reduce the risk to a level of tolerance set by the target score. This format will continue to evolve as part of the risk transformation programme; however, a simple guidance note will be developed to assist Board and Committee members to interpret the BAF, address some of the issues raised in the Structured Assessment and provide proportionate challenge on actions to mitigate the risks and their intended impact. This guidance will be developed by 1st April 2023.

8. Risks are allocated to appropriate Directors to drive the reviews and actions to mitigate the risks. In addition to directorate reviews there are formal risk review discussions with the Assistant Directors Leadership Team (ADLT) and the Executive Management Team (EMT) in relation to risk escalation, changes in ratings, and any new risks for inclusion on the Corporate Risk Register.

9. This executive summary demonstrates that focus is maintained on management and mitigation of the Trust's Corporate Risks and particularly those high rated risks with scores of 25 and 20. It draws together those broader discussions and signposts the Board accordingly. In addition, the Risk Owners will have an opportunity to add to this narrative during the meeting and Committee Chairs will also provide further assurance or escalations as appropriate, drawing from the Alert, Advise, Assure reports (AAA).

10. **Risks 223** (the Trust's inability to reach patients in the community causing patient harm and death) and **risk 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) are both rated 25:

    10.1. Despite a reduction in delays over January and February 2023, current handover delays have demonstrated a deteriorating picture with March 2023 delays at December 2022 levels.
    10.2. During industrial action days there was reduced handover delays at Health Boards which maximised WAST resources. Despite a reduced volume of conveyance as a result of the industrial action, there is a demonstration that reduced handover delays are achievable, and this therefore warrants a triangulation of data and learning.
    10.3. The actions which were contained in the July 2022 Board paper on avoidable harm have been included in the action section of the BAF for both risks. A progress reports on these actions is reported to each Board meeting.
    10.4. The Quality, Patient Experience and Safety Committee (QUEST) reviews both risks at its meetings. The February meeting reviewed the patient safety report for Q3 and related metrics related to patient safety and avoidable harm in the MIQPR. The Committee AAA report for this Board meeting draws out the discussion held at that meeting on the number of concerns raised, immediate release direction refusals (both Red and Amber 1), and incidents linked to timeliness of response, demonstrating more pace is required to address the issue at a system and strategic level.

10.5. Additionally, both of these risks are presented to the Finance & Performance Committee and People & Culture Committee for wider discussion and perspectives.

10.6. The Monthly Integrated Quality and Performance Report (MIQPR) includes further analysis of performance and handover delays, post production lost hours, together with remedial plans and improvement trajectories.

10.7. The Chief Executive's report sets out participation in, and discussion at, regular stakeholder meetings with NHS Wales CEOs, the Director General of NHS Wales, Commissioners and EASC where stakeholder actions and progress is discussed.

11. **Risk 160** (high absence rates impacting on patient safety, staff wellbeing and the Trust's ability to provide a safe and effective service) is rated 20; however, is expected to reduce in score in the next round of governance given the mitigations in place:

11.1. The People and Culture Committee in March 2023 focused on the challenging situation which included a prolonged period of industrial action and winter pressures.

11.2. Progress against the improving attendance programme of work was presented to the People and Culture Committee in March showing reducing levels of sickness absence, and actions to address recommendations in the reasonable assurance absence management internal audit were monitored.

11.3. The Committee also reviewed this risk alongside the MIQPR which sets out further analysis and remedial plans for sickness absence improvement.

11.4. The Executive Management Team review the sickness absence management programme on a regular basis.

11.5. A recent deep dive presented to the Executive Management Team broke down sickness by demographics and potential drivers with further work underway to look at this in more detail, particularly to work-related and personal stress absence drivers.

12. **Risk 201** (damage to the Trust's reputation following a loss of stakeholder confidence) is currently rated 20:

12.1. The Board approved the engagement framework at its meeting on 28th July 2022 and the delivery plan on the 23rd January 2023.

12.2. This risk was discussed at the People and Culture Committee on 14th March 2023.

12.3. The MIQPR and sets out the engagement work underway by the patient experience and community involvement teams.

12.4. The current risk score is expected to remain at 20.

12.5. To protect and enhance the Trust's reputation, the Partnerships and Engagement Directorate will continue to ensure its stakeholder engagement activity and media activity is robust. Work closely continues with PWC to further inform the detail of future engagement.

12.6. Routine stakeholder and staff engagement continues, including the recent round of Executive roadshows and WAST Live.

12.7. The outcome of the recent reputation audit will be reported through to the EMT in April 2023 and onward to the People and Culture Committee.

13. There are third line of defence assurances which will provide a greater level of assurance against controls for some of these higher rated risks, and these relate to

internal audit reviews on immediate release requests and sickness absence management.

RECOMMENDATION:

14. **Members are asked to consider and discuss the contents of the report and:**
    a) **Note the review of Risk 223, 224, 201 and 160 including mitigating actions.**
    b) **Note the development of a suite of new risks.**
    c) **Note the update on the Risk Management Transformation Programme.**

KEY ISSUES/IMPLICATIONS
The key issues and implications are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
Each of the Corporate Risks were considered by the following Committees, as relevant to their remit, during the reporting period: a) **Quality, Safety & Patient Experience** (10th February 2023) b) **People & Culture Committee** (14th March 2023) c) **Finance & Performance Committee** (21st March 2023)

REPORT ANNEXES
• SBAR report. • Annex 1 - Summary table describing the Trust's Corporate Risks. • Annex 2 – Scoring Matrix • Annex 3 – Frequency of Risk review • Annex 4 - Board Assurance Framework

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, an overview of the current risk management framework with particular focus on assurance to Committees and the Board, and detail of the risk programme within the IMTP.

2. A summary of the Trust's 16 principal risks on the corporate risk register as at 22nd March 2023 is detailed in Annex 1; however, given current operational pressures including Industrial Action and absence in the team, only the highest scoring risks have been formally reviewed; Risks 223, 224, 201 and 160. A programme of work has been established to fully review all corporate risks, including the development of any new risks, ahead of the next Board and Committee meetings in May 2023.

BACKGROUND

3. As a result of discussion at the Board meeting on 28th July 2022 regarding its engagement on the higher rated risks, the executive summary of the Board risk management report was adjusted to provide more focus on the highest rated risks.

4. That report highlighted the focus that is maintained on management of the higher rated risks, not only as a result of risk discussions in various forums including Assistant Directors Leadership Team (ADLT) and Executive Management Team (EMT) and the Committees, but as a result of broader attention to planned mitigations. The report draws together those broader discussions and signposts the Board accordingly.

5. At the Board meeting on 26th January 2023 the Chair of the Audit Committee sought further clarity on the roles and responsibilities for risk management within the existing framework, in particular the role of the Executives, the Committees and the Board with respect to the higher rated risks.

6. The Audit Committee then received a report on 2nd March 2023 which provided assurances in respect of the management of the Trust's principal risks, an overview of the current risk management framework with particular focus on assurance to Committees and the Board, in addition to detail of the risk transformation programme for the Integrated Medium Term Plan (IMTP) 2023-26.

ASSESSMENT

7. The principal risks are set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 2.

Corporate Risks

8. The full detail of each Corporate Risk, including controls, assurances, gaps and mitigating actions form part of the improved Board Assurance Framework (BAF) detailed in Annex 2.

9. In addition, Members are asked to note that the actions, which were contained in the July 2022 Board paper on avoidable harm and further outlined at the meeting in November 2022, are included in the action section of the BAF for the Trust's highest scoring risks 223 and 224 which are both rated 25. These actions continue to seek to mitigate in real time, avoidable harm in the context of extreme and sustained pressure across the urgent and emergency care service.

Development of New Corporate Risks

10. **NEW Civil Contingencies Risk** - *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*

    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*

    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*

11. The Board were advised in January 2023 that the Chief Executive had written to Health Board Chief Executives regarding their Civil Contingency plans and has received assurances that plans and will be activated in the event of a major incident.

12. The full detail of the risk, including controls, assurances and mitigating actions is in the process of being articulated and the Executive Risk Owner, ADLT and EMT will consider this through governance ahead of the next Board meeting in May 2023.

13. **Risk 538** - A risk has been developed to reflect the possible consequence of a further delay to the implementation of the new Integrated Information System (Salus); however, due to ongoing commercial discussions and a delay to some delivery milestones, the detail of this risk will need to be reviewed and finalised to capture the emerging position and differentiate it from any realised issues. The risk assessment will be finalised ahead of presentation to Trust Board in May 2023.

14. **Risk 542** - *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan*

    This risk has been fully articulated; however, now needs to navigate Trust risk governance processes. It is expected that this will be included on the CRR and reported at the May 2023 Trust Board meeting.

15. Additional risks in development and navigating Risk governance are:

    a. Risks to the reputation of the Trust's Charity and Trustees due to late filing of accounts.
    b. Integrated technical planning capability and capacity.
    c. Capacity within teams to deal with volume of complex requests i.e. Putting Things Right Team.

Risk Management Framework

16. The Risk Management Transformation Programme is included in the IMTP 2023-26 and includes the elements that comprise the Risk Framework, including the Risk Policy, Procedures and Guidance, as well as training and education. In addition, it includes the development of a BAF that reflects more closely the Trust's strategic objectives against its long term strategy – Delivering Excellence: Vision 2030.

17. The Risk Management Policy that is in development sets out the various roles and responsibilities in more detail, and the risk management framework will include a BAF standard operating procedure, training and guidance. However, there are some measures that are proposed in the interim to further strengthen risk management, and which were agreed at the Audit Committee on 2nd March as follows:

    - Presentation of risk at Board: The standalone risk paper presented to Board will be retained which demonstrates in the executive summary where focus is maintained on management and mitigation of the principal risks rated 25 and 20, drawing together those broader discussions and signposting the Board accordingly. In addition, the risk owners will have an opportunity to add to that narrative and that which is contained in the full BAF document, with Committee Chairs providing further assurance or escalations as appropriate, drawing from their AAA reports. This will afford the Board as a whole an opportunity to scrutinise further to ensure mitigating actions are achieving their maximum impact.

    - Guidance on interpretation of the BAF: As a result of feedback in the Audit Wales Structured Assessment a simple guidance note will be developed to assist Board and Committee members to interpret the BAF, address some of the issues raised in the Structured Assessment and provide proportionate challenge on actions to mitigate the risks and their intended impact. This guidance will be developed by 1st April 2023.

18. Internal Audit are due to commence their review of risk management and assurance in March/April 2023.

RECOMMENDED

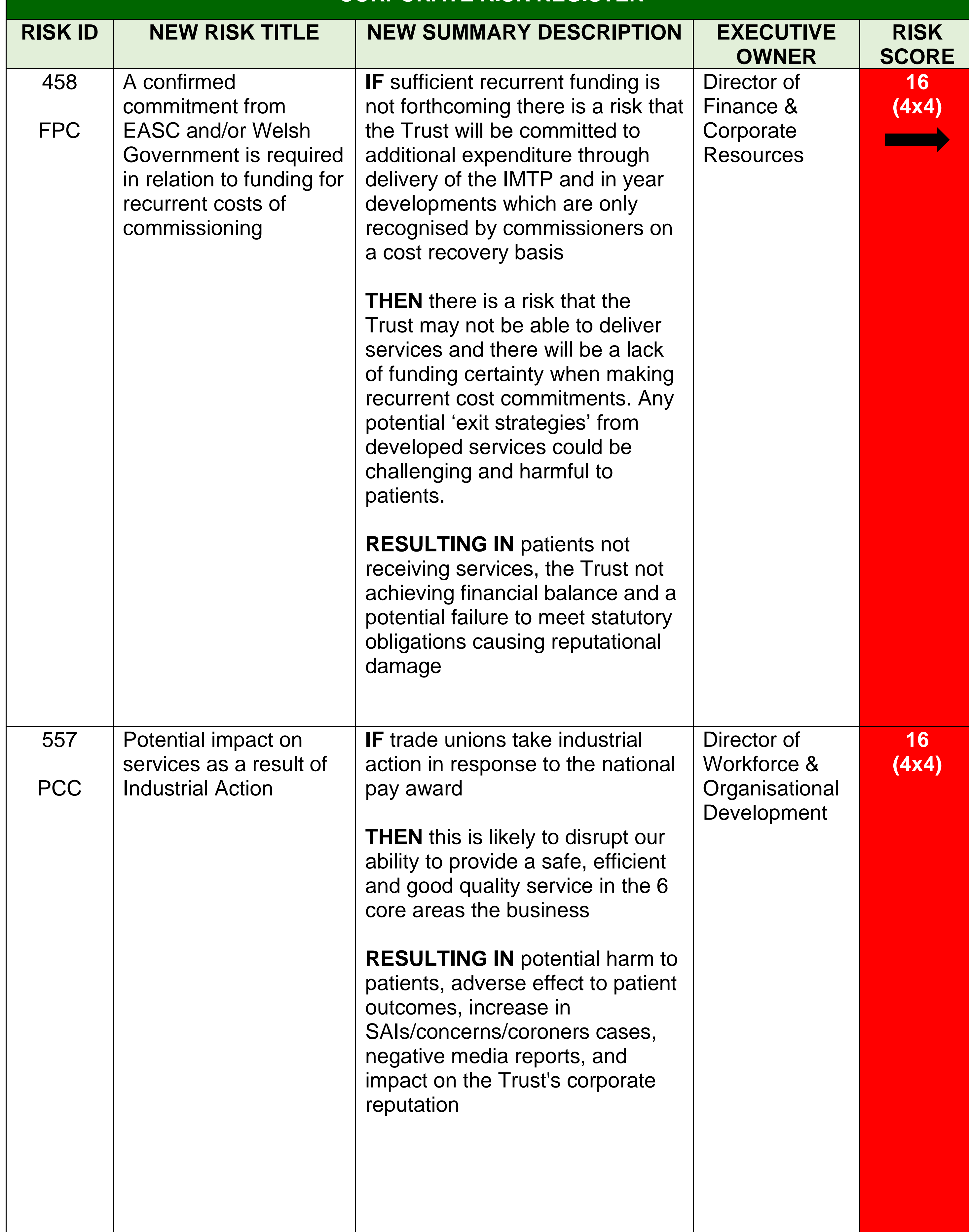
19. **Members are asked to consider and discuss the contents of the report and:**
    a) **Note the review of Risk 223, 224, 201 and 160 including mitigating actions.**
    b) **Note the development of a suite of new risks.**

c) **Note the further measures in place and the update to the Risk Management Transformation Programme.**

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)**
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)**
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	**IF** there are high levels of absence **THEN** there is a risk that there is a reduced resource capacity **RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of Workforce & Organisational Development	**20 (5x4)**
201 PCC	Damage to Trust reputation following a loss of stakeholder confidence	**IF** the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations **THEN** there is a risk of a loss of stakeholder confidence in the Trust **RESULTING IN** damage to reputation and increased external scrutiny	Director of Partnerships & Engagement	**20 (4x5)**

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **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	Director of Finance & Corporate Resources	**16 (4x4)** ➡
245 FPC	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	**IF** CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident **THEN** there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities **RESULTING IN** potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)	Director of Operations	**16 (4x4)** ➡



CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	**IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients. **RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage	Director of Finance & Corporate Resources	**16 (4x4)**
557 PCC	Potential impact on services as a result of Industrial Action	**IF** trade unions take industrial action in response to the national pay award **THEN** this is likely to disrupt our ability to provide a safe, efficient and good quality service in the 6 core areas the business **RESULTING IN** potential harm to patients, adverse effect to patient outcomes, increase in SAIs/concerns/coroners cases, negative media reports, and impact on the Trust's corporate reputation	Director of Workforce & Organisational Development	**16 (4x4)**

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
199 PCC	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	**IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance **THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments **RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation	Director of Quality & Nursing	**15 (3x5)** ➡
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**15 (3x5)** ➡
543 FPC	Major disruptive incident resulting in a loss of critical IT systems	**IF** there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems **THEN** there is a risk of a loss of critical IT systems **RESULTING IN** a partial or total interruption in WAST's effective ability to deliver essential services	Director of Digital Services	**15 (3x5)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	**IF** significant internal and external system pressures continue **THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST **RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of Workforce & Organisational Development	**15 (3x5)** ➡
100 FPC	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	**IF** WAST fails to persuade EASC/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 and staff and key outcomes within the IMTP not being delivered	Director of Strategy Planning & Performance	**12 (3x4)** ➡
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	**IF** the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained **THEN** there is a risk that Trade Union 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.	Director of Workforce & Organisational Development	**12 (3x4)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
283 FPC	Failure to implement the EMS Operational Transformation Programme	**IF** there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme **THEN** there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters **RESULTING IN** potential patient harm, deterioration in staff wellbeing and reputational damage	Director of Strategy Planning & Performance	**12 (3x4)** ➡
424 FPC	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	**IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139) **THEN** there is a risk that there is insufficient capacity to deliver the IMTP **RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing	Director of Strategy Planning and Performance	**12 (3x4)** ➡

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	ocal media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Highly Unlikely: Will probably never happen/recur	**Not for years**	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	**At least annually**	2	4	6	8	10
3 Likely: It might happen/recur occasionally	**At least monthly**	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	**At least weekly**	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	**At least daily**	5	10	15	20	25

Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

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:	21/03/2023	TREND	25 (5x5)
			Date of Next Review:	22/04/2023	➡	

IF significant internal and external system pressures continue	**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community	**RESULTING IN** patient harm and death		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

IMTP Deliverable Numbers: 3, 7,9,11, 12, 14,16, 18, 21, 22, 26

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

CONTROLS	ASSURANCES
1. Patient Flow Co-Ordination based in the Grange University Hospital	**Internal** **Management (1st Line of Assurance)** 1. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU
2. Regional Escalation Protocol	2. Daily conference calls to agree RE levels in conjunction with Health Boards
3. Immediate release protocol	3. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
4. Resource Escalation Action Plan (REAP)	4. Weekly review by Senior Operations team with assessment of action compliance. 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.
5. 24/7 Operational Delivery Unit (ODU)	5. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
6. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans	6. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
7. Limited Alternative Care Pathways in place	7. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
8. Consult and Close (previously Hear and Treat)	8. Monitoring CSD rates through AQIs. Consult and Close volumes form part of EMS CCC weekly reports to SLT. Regular reporting of incident volumes to Operational Review Groups. Summary level information about Consult and Close volumes, targets, trends and recontact rates reported to TB and sub-committees. Metrics relating to Ambulance Quality Indicators (AQI) published on a quarterly basis by EASC. Bi-monthly EASC Provider reports. Consult and Close performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information Management Internal Audit report February 2022 (External Assurance). Consult and Close rate has increased from 12% to circa 15% March 2023.
9. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	9. Qlik sense APP dashboard monitors performance and provides assurance that APPs are flowing patients into alternatives to emergency department. Qlik sense is a national report and can drill down into regional, local and individual performance as required. APP Navigation – Test of Change Framework (Swansea Bay & Hywel Dda). Review of despatch criteria for APPs.
10. Clinical Safety Plan	10. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
11. Recruitment and deployment of CFRs	11. Volunteers are another resource for response, Volunteer
12. ETA scripting	12. The ETA Dashboard is a tactic that was signed off by EMT – there is a dashboard that supports scripting analysed by comparing with real time data
13. Clinical Contact Centre (CCC) emergency rule	13. CCC Emergency Rule is policy that has been signed off by Execs.
14. National Risk Huddle	14. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
15.	15.
16. Summer/Winter initiatives	16. Monitoring through SLT and STB
17. CHARU implementation	17. Monitored via the EMS project Board
18. National Transfer & Discharge Model	18.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	21/03/2023	TREND	25 (5x5)
			Date of Next Review:	22/04/2023	➡	

IF significant internal and external system pressures continue	**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community	**RESULTING IN** patient harm and death		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

19. Conveyance Reduction	19. This is part of the weekly performance review and aligned to Care Closer to Home Programme
20. Access to Same Day Emergency Care (SDEC) for paramedic referrals	20. This forms part of the handover improvement plans in place with Health Boards, however assurance is limited given that the acceptance of paramedic referrals is low (less than 1%) and inconsistent.
21. Mental Health Practitioners in cars	21.
22. Roll out of ECNS	22. Reported through QuEST
23. Clinical Model and clinical review of code sets	23. Reported through QuEST
24. Remote Clinical Support Strategy	24. Strategic Transformation Board – IMTP deliverable
25. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	25. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)
26. Information sharing	26. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	None immediately identified but subject to continual review.
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow	
3. Covid capacity streaming	
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding	
5. Local delivery units mirroring WAST ODU	
6. Handover delays link to risk 224	
7. Risk tolerance in Health Boards appears inconsistent as does the offer of dynamic plans to alleviate or respond to hospital handover delays. Despite some reduction in delays over January and February 2023, current handover delays have demonstrated a deteriorating picture more closely reflecting December 2022 than January and February 2023.	
8. During industrial action days, Health Boards demonstrated compliance with reducing handover delays in order to maximise WAST resources. Despite a reduced volume of conveyance as a result of the industrial action, there is however a demonstration that reduced handover delays are achievable, and this therefore warrants a triangulation of data.	
9. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 6 months there is a low confidence in attaining this.	
10. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration	
11. Patient Flow Co-ordinators - Health Boards to consider the value of deploying PFCs at emergency departments to aid flow	
12. Handover Improvement Plans agreed between WAST and Health Boards	12. Handover Improvement Plans have been replaced by ICAPS and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays
18.	18. National Transfer & Discharge model is yet to be determined. A task and finish has been established to progress this piece of work
21.	21. Mental Health Practitioners – not yet implemented but part of the Care Closer to Home workstream
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

<table>
<tr><td>Risk ID 223</td><td colspan="3">The Trust's inability to reach patients in the community causing patient harm and death</td><td>Date of Review:</td><td>21/03/2023</td><td>TREND</td><td rowspan="2">25 (5x5)</td></tr>
<tr><td></td><td colspan="3"></td><td>Date of Next Review:</td><td>22/04/2023</td><td>➡</td></tr>
<tr><td colspan="2" rowspan="4">IF significant internal and external system pressures continue</td><td rowspan="4">THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community</td><td rowspan="4">RESULTING IN patient harm and death</td><td></td><td>Likelihood</td><td>Consequence</td><td>Score</td></tr>
<tr><td>Inherent</td><td>4</td><td>5</td><td>20</td></tr>
<tr><td>Current</td><td>5</td><td>5</td><td>25</td></tr>
<tr><td>Target</td><td>2</td><td>5</td><td>10</td></tr>
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Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Paused	
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	Complete	Majority of EMS rosters complete and implemented
4. Transition arrangements post pandemic	Executive Pandemic Team / Assistant Director of Strategic Planning (BCRT Chair)	Complete 30/08/22	Transition complete
5. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	TBA	TBA	
6. Maximise the opportunity from Consult and Close – stretch to 15% and beyond (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, Integrated Care	31.03.23	Work undertaken to map influences and progress towards each. Current % of Consult and Close increased from 12% to 15% at March 2023.
7. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support	Complete	System in place and ongoing.
8. Weekly REAP review by senior Operations Directorate team with assessment of action compliance (I) Source: Action Plan presented to Trust Board 28/07/22]	Director of Operations / Operations Senior Leadership Team	Complete	In place and ongoing - Weekly Performance Meetings occur every Tuesday lunchtime to review performance, etc. and determine REAP level.
9. Recruitment and deployment of new CFRs (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support / National Volunteer Manager	Complete 21.03.23	Additional CFR Trainers and Operations Assistants appointed to support recruitment and training of new CFRs. Volunteer Management Team, supported by the Volunteer Steering Group, now embarking on volunteer recruitment programme and increasing public engagement to raise awareness about volunteering opportunities available within WAST. Volunteer team has recruited and trained 173 additional volunteers between November and March 2023.
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]			
11. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	TBA	Level 2 Falls Service implemented as a pilot. Awaiting evaluation of the pilot and assessment of outcomes and potential longevity of this initiative. Falls service in place with enhanced day and night provision; Utilisation of resources reviewed at weekly performance meetings by Operations SLT.
12. External Controls detailed within the Action Plan presented to Trust Board on 28/07/22: a. Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E) b. Consideration of additional WAST schemes to support risk mitigation through winter (I) c. NHS Wales educes emergency department handover lost hours by 25% (E) d. NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E) e. Alterative capacity equivalent to 1000 beds (E) f. Implement nationwide approach to emergency department 'Fit 2 Sit' (E) g. Implementation of Same Day Emergency Care services in each Health Board (E) h. National Six Goals programme for Urgent and Emergency Car (E)			

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:	16/03/2023	TREND	25 (5x5)
		Date of Next Review:	17/04/2023	→	

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

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

IMTP Deliverable Numbers: 7,9, 10, 11, 12, 13, 14, 15, 16, 23, 24, 25, 26, 33, 35

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Delivery Unit under the Joint Investigation Framework which is currently in pilot phase and an evaluation is to be undertaken in quarter 1 2023/24 by EASC. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance – the pilot is in progress ,.and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.	5. Monthly Integrated Quality and Performance Report
6. Hospital Ambulance Liaison Officer (HALO) (Some health Boards).	6.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours.	7. 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 is via the Strategic Command structure.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process.
9. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.	9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end.
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.

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:	16/03/2023	TREND	25 (5x5)
		Date of Next Review:	17/04/2023	➡	

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

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

12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.	12. Integrated Quality and Performance Report (December 2022 overall 84% - mandatory training target just below target at 84.6%.
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board January 2023 and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.
16. Implementation of Duty of Quality, Duty of Candour and new Quality Standards requirements in April 2023 (soft launch).	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of February 2023 is 'Implementing and operationalising'. 17.
	External Sources of Assurance **Management (1st Line of Assurance)**
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC) and Joint Executive Team (JET) meeting Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.	1. Strengthen and triangulate patient safety metrics and look back data at ED, service and corporate level for baseline data for improvement projects and WAST reports.
2. Inconsistent review of potentially serious / catastrophic patient safety incidents in line with the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019 (frequently referenced as 'Appendix B' Reports) by Health Boards pan NHS Wales and lack of ownership of system risks. Lack of whole system approach to handling patient safety incidents resulting from system pressures*.	2. Implementation of revised process, engagement and outcome and improvement measures at system level – early work commenced with the pilot in progress of the Joint Investigation Framework. Reviews of cases still progressing by Health Boards update requested by QuEST February 2023.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales*.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. 2,098 hours were lost in December 2022, an increase compared to 18,773 lost hours in December 2021.

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:	16/03/2023	TREND	25 (5x5)
		Date of Next Review:	17/04/2023	➡	

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

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

4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5. (a) Variation in appetite across the Health Boards to implement Fit2Sit, citing overcrowded emergency department waiting rooms as the reason. Limited confidence in system engagement to address Goal 4 and achieve reduction in handover delays*. 5. (b) Protracted timescales in the Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – by the end of April 2025. The number of people waiting over this period for ambulance patient handover will reduce on an annual basis until that point'. No detail on incremental improvements required at emergency department level or oversight mechanisms. EASC have stated that no delay should exceed 4 hours although WAST is yet to see any demonstrable plans to support this*.	5. 15-minute handover target is not being achieved pan-Wales consistently. Fit to Sit programme is not progressing currently.
6. Variation pan Wales / England as position not implemented across all emergency departments*.	6.
7.	7.
8. Variation pan Wales / England as position not implemented across all emergency departments*.	8. Health & Care Standards self – assessment in progress.
9. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	9.
10.	10.
11. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	11.
12.	12.
13. Transition to ePCR impacting on data temporarily	13.
14. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas*.	14. HIW approve and sign off WAST elements of recommendations.
15.	15.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators
	2. Lack of collective system response to HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report. Meetings cancelled x 2 in May 2022. WAST has representation on the working group*

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026 – Goal 4: Rapid response in physical or mental health crisis.	CEO / NHS Wales System Leaders	• Checkpoint Q1 2023/24	• Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales • WAST will be represented on the Clinical Reference Group by Andy Swinburn with first meeting now held. • The Trust recently reported to EASC that is has further updated how it maps into six goals programmes. The programme structure nationally is being embedded and the Trust now has presence on goals 2, 5 & 6 at delivery board level and on the clinical advisory board.

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:**	**16/03/2023**	TREND	25 (5x5)
		Date of Next Review:	**17/04/2023**	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	**RESULTING IN** patients coming to significant harm and a poor patient experience		Likelihood	Consequence	Score
			Inherent	5	5	25
			Current	5	5	25
			Target	3	2	6

Action	Lead	Timescale	Progress
2. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• Checkpoint Q1 2023/24	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
3. Implement nationwide approach to emergency department 'Fit 2 Sit'	Chief Medical Officer / Chief Nursing Officer	• Checkpoint Q2 2023/24	• Acceptance at meeting of Chairs and CEOs led by JP on 8/6 that a national approach to Fit 2 Sit should be adopted • Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit. • Fit to Sit SBAR (06 September 2022) sent to the Trust from the NCCU. To be discussed at the next IQPD meeting to focus on the variation in practice being seen. • More data identified as a key area for development before an evaluation can take place.
4. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	• Checkpoint Q2 2023/24	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. Workshop planned in May 2023 • Access to ePCR data (NEWS) now available. Work on-going with Health Informatics regarding patient safety dashboards.
5. Continued Health Board interactions – my next patient, patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly • Checkpoint Q2 2023/24	• Monthly meetings continue to be held and the content of the health board reports are currently under review.
6. HIW Improvement Plan / Workshop– WAST inputs / influencing improvements Response and improvement actions to Healthcare Inspectorate Wales Inspection report (2021) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' which links to Fundamentals of Care.	Assistant Director of Quality & Nursing	• Checkpoint Q2 2023/24	• Awaiting HIW feedback.
7. Participation in the CASC led workshop to reform *the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019*.	Executive Director of Quality & Nursing	• Checkpoint post pilot Q1 2023/24	• Revised joint investigation approach agreed and now in pilot phase.
8. Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of Workforce & Organisational Development	• Checkpoint Q1 2023/24	• Strong focus from Executives with detailed updates to EMT every two weeks. • Good progress with pilot of payment of the C1 license proving particularly effective. • The Trust has 90 of the additional 100 required already in the organisation, 60 of these staff will be operational on or before 23 Jan-23 and 30 more will come through training the following month. By the end of Mar-23, the Trust will be at 99.5% of the new establishment. The reason for the slight slippage is significantly increased attrition over the past two months against forecast. The Trust has carried out exit interviews to understand the reasons for this increase.

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:	16/03/2023	TREND	25 (5x5)
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			Inherent	5	5	25
			Current	5	5	25
			Target	3	2	6

Action	Owner	Checkpoint	Progress
9. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Checkpoint Q4 2023/24	• Bid not successful. Feedback received from Welsh Government that will be incorporated into future bids. However, Trust decision to proceed with 18 MSC places. 10 started in September (North) with the balance (eight) on target for March 2023 start.
10. Senior system influencing	Trust Chair Chief Executive Officer	• Checkpoint Q2 2023/24	• CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant for a. Specific discussions for example at recent Chief Executive Leadership team meeting around plans for winter to reduce harm. • As a result of ongoing escalation of these issues, the Minister met with CEOs and Chairs from all health boards and WAST on the 28th November 2023. Presentations were given by colleagues from Walsall, where handovers have remained low. The minister set out her expectation that health boards would meet the reductions as previously agreed.
11. Emergency Department cohorting	Director of Operations	• Closed	• Evaluation of cohorting has been completed and as a result, there has been an agreement to terminate these arrangements in Morriston and GUH.
12. Transition Plan	Chief Executive Officer	• Checkpoint Q2 2023/24	• Formally submitted to Commissioners in December 2021. As above +100 FTEs secured although non-recurring at this point in time. • Also as above, funding for additional APPs not secured via Value Based Healthcare fund; however, decision of Trust to proceed with take up of 18 MSC places anyway. • Further discussions with funders as part of IMTP 2023-2026 required and also possible rebasing of EMS Demand & Capacity Review with increased system pressures built in, during 2023. This is now a required action with terms of reference to be developed. • A report is currently being developed on what the Trust could recruit in 2023/24 if funding is available. This report will come into EMT on w/c 23 Jan-2023.
13. Overnight falls service extension	Executive Director of Quality & Nursing	• • June 2023	• A Falls Utilisation Task and Finish Group has been set up. • Night Car Scheme extension agreed to 31 March 2023 (2 regional resources) • Context, further additional Falls SJAC resources agreed for winter pressures (external to contract until the end of financial year). Phased delivery

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:**	**16/03/2023**	TREND	**25 (5x5)**
		Date of Next Review:	**17/04/2023**	➡	

				Likelihood	Consequence	Score
IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	**RESULTING IN** patients coming to significant harm and a poor patient experience	**Inherent**	5	5	25
			Current	5	5	25
			Target	3	2	6

			(phase 1 and 2 online, increased 4 day resources), two additional night resources 01 Feb-23 & 01 Mar-23. • Falls level 1 and 2 impact evaluation report completed -presenting to Clinical Quality Governance Group 18 Jan-23. • Task & Finish group and approved by CPAS, which went live 08 November 2022. Anticipated to support sustained improved utilisation. • The Trust now has 6 ideal code sets.
14. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	Chief Executive Officer	• Checkpoint Q2 2023/24	• Conducted in three phases over the next 6 to 9 months Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance and support). • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Audit Wales updated the Audit Committee on the Review of Unscheduled Care work they are undertaking at its meeting on 15 September 2022.
15. Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	• Checkpoint Q2 2023/24	• Winter modelling complete and being reported to Welsh Government via Joint Executive Team meeting (16 November 2022). • Winter schemes identified and funded e.g., additional UCS, additional overtime etc. • Performance Improvement Plan (the Trust's rolling tactical seasonal plan up to date). • Good progress on Performance Improvement Plan (pip) (and associated schemes). There were only 15 PIP actions live in Dec-22, so the PIP has been closed down and the remaining actions transferred into other assurance mechanisms like this report. • Specific seasonal and strike structures stood up. • Trust demonstrating continued focus and creativity on approach to seasonal and strike mitigations. • Work ongoing on development of a Welfare and Sitting service. • Work commenced to understand red coding better and to model additional resources that might be required.

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:	16/03/2023	TREND	25 (5x5)
		Date of Next Review:	17/04/2023	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	**RESULTING IN** patients coming to significant harm and a poor patient experience		Likelihood	Consequence	Score
			Inherent	5	5	25
			Current	5	5	25
			Target	3	2	6

16. National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	• Checkpoint Q4 2022/23	• The national awareness campaign is now live through to the end of the financial year. • Soft launch (14 November 2022) with digital etc. • The planned care pages are now live on NHS 111 Wales. Released a new homepage: providing new and more dynamically updateable content, and more optimised for mobile. • Redesign of the Health A-Z & Check your symptoms sections. • The NHS style guide was incorporated across all areas of 111.Wales providing a consistent design across all pages. • Complete linking of new web-guides to DOS / Health A-Z articles thereby improving signposting • Search functionality has been improved increasing the relevancy of returned results. • Essential updates of the symptom checkers completed. • The Trust made the decision to postpone the second phase of the campaign due to the pressures seen in the run up to Christmas. The second phase will now launch 28 Feb-23, just after the Welsh Government's Help Us Help You campaign has concluded. This will include the TV and radio advert, new organic and paid digital, influencer content and case studies.
17. 24/7 Operational oversight by ODU with dynamic review and system escalation as required	Director of Operations	• Checkpoint Q2 2023/24	• Welsh Government funding provided to each Health Board to implement SDEC. • WAST has nationally agreed referral rights to these services enabling us to avoid the emergency department with suitable patients. • The Trust has provided Welsh Government with information which indicates that SDEC referrals account for less than 1% of the Trust's verified EMS demand. • As a result Welsh Government has asked the Trust to forecast and model the potential level of patient flow into the existing and proposed SDEC if operating properly. • The results of the modelling are expected w/c 23 Jan-2023.
18. Implementation of Same Day Emergency Care (SDEC) services in each Health Board NHS	LHB CEOs	• Checkpoint Q2 2023/24	• Commitment made at EASC in October 2021. • Commitment reaffirmed by Minister in CEO and Chair meeting on 23 Jun-22. • The Trust has calculated that a 25% reduction from the October 2021 position would return handover lost hours to the levels being seen in

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:	16/03/2023	TREND	25 (5x5)
		Date of Next Review:	17/04/2023	→	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	**RESULTING IN** patients coming to significant harm and a poor patient experience		Likelihood	Consequence	Score
			Inherent	5	5	25
			Current	5	5	25
			Target	3	2	6

19. Wales eradicates all emergency department handover delays in excess of 4 hours			the winter pre-pandemic e.g. 14,000 hours. In Dec-22 the Trust lost 32,050 hours to hospital handover or 37% of its conveying capacity. This figure does not include English hospitals, so in reality it is even higher. The levels are extreme. • Commitment made at EASC in October 2021 • Commitment reaffirmed by Minister in CEO and Chair meeting on 23/6. • There were over 2,883 +4 hour patient handovers in December 2022; the target being 0 from September 2022.
20. Alternative capacity equivalent to 1,000 beds	LHB CEOs	• Checkpoint Q2 2023/24	• Led by CS on behalf of all CEOs this work emerging from a CEO away day held on 22 April seeks to establish alternative capacity equivalent to 1000 beds (roughly the number of medically fit for discharge patients nationally held in acute beds) • As a shared/collaborative endeavour with Local Authorities who hold the statutory responsibility for the provision of social care local plans are being developed to boost step down beds, domiciliary care and so on. • Most recent intelligence suggested that around 50% of this capacity had been secured (needs to be confirmed).
21. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 (soft launch with Welsh Government Roadmap in place).	Executive Director of Quality & Nursing	• Checkpoint Q1 2023/24	• Monthly updates to progress against actions following the baseline assessment and readiness returns. • Further presentation on Duty of Quality and Duty of Candour readiness and implementation plan to be presented and discussed at the Trust Board Development Day planned for 29.03.2023.

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	21/03/2023	TREND	20 (5x4)
		Date of Next Review:	22/04/2023	➡	

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

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	5	4	20
Target	3	4	12

IMTP Deliverable Numbers: 1,5, 9, 10, 12, 17, 18, 19, 20, 26, 34

EXECUTIVE OWNER	Director of Workforce & Organisational Development	ASSURANCE COMMITTEE	People and Culture Committee

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Managing Attendance at Work Policy/Procedures in place	1. (a) Policy reviews to ensure policies and procedures are fit for purpose (b) Audits by People Services on sickness
2. Respect and Resolution Policy	2. Policy reviews to ensure policies and procedures are fit for purpose
3. Raising Concerns Policy	3. Policy reviews to ensure policies and procedures are fit for purpose
4. Health and Wellbeing Strategy	4.
5. Operational Workforce Recruitment Plans	5.
6. Roster Review & Implementation	6.
7. Return to Work interviews are undertaken	7.
8. Training	8.
9. Directors receives monthly email with setting out ESR sickness data	9.
10. Operational managers receive daily sickness absence data via GRS	10.
11. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme	11.
12. WAST Keep Talking (mental health portal)	12.
13. Suicide first aiders	13.
14. TRiM	14.
15. Peer Support network	15.
16. Coaching and mentoring framework	16.
17. Staff surveys	17.
18. Stress risk assessments	18.
19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC	19. Sickness forms part of Workforce Scorecard to People & Culture Committee
20. External agency support e.g. St John Ambulance, Fire and Rescue	20.
21. Strategic Equality Objectives	21. Policy reviews to ensure policies and procedures are fit for purpose
22. Volunteers	22.
23. Monthly reviews of colleagues on Alternative duties	23. Action plans arising from meetings with colleagues implemented through monthly diarised meetings
24. Manager guidance on managing Alternative duties	24.
25. Fortnightly report on absence to EMT and report to every meeting of People & Culture Committee	25. Minuted meetings and action logs for EMT & People & Culture Committee
26. Sickness audits for localities	26.
27. Additional support for areas with higher than average absence	27.
	External Management (2nd Line of Assurance)
	1a. All Wales review of All Wales Attendance at Work Policy
	Independent Assurance (3rd Line of Assurance)
	1b. Internal Audits scheduled through Shared Services Partnership (controls 1 - 24)
	2. Audit Wales – Taking Care of the Carers report in October 2021 (controls 1 - 24)

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	21/03/2023	TREND	20 (5x4)
		Date of Next Review:	22/04/2023	→	

IF there are high levels of absence e.g. sickness and alternative duties	**THEN** there is a risk that there is reduced resource capacity	**RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	5	4	20
			Target	3	4	12

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. (a) Consistency and Application in Managing Attendance at Work Policy (b) Education and communication with managers about resources available and how to implement it e.g. stress risk assessments	1. There are other factors that impact on sickness which can't be controlled
4a. Wellbeing policy currently being produced	8. Reporting on training compliance
9 and 10 It is not known what is undertaken with respect to the data covered in assurances 9 and 10 once it is received	9, 10 and 19 Absence data is not updated in a timely manner into ESR by managers
1 – 22 Education and communication with managers about resources available and how to implement it e.g. stress risk assessments	
	External Gaps in Assurance None identified at the present moment

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Implementation of Improving Attendance project	Deputy Director of Workforce & OD	31.09.23	Underway and ongoing. Downward trajectory 8.77% for November 2022.
2. Implementation of Behaviours Refresh Plan	Assistant Director – Inclusion, Culture and Wellbeing	31.10.22 Extended to 31.05.23	Underway and ongoing. Captured in the IMTP for the service. Impacted by IA
3. Long term sickness absence deep dive	Deputy Director of Workforce & OD	31.07.23	Underway and ongoing. Downward trajectory in levels of long term absence
4 . Develop guidance for line managers to support addressing challenging conversations and change	Deputy Director of Workforce & OD	31.07.22 Complete	Training produced and rolled out. Now BAU
5. Roll out platform for raising concerns (in relation to Freedom to Speak Up Arrangements)	Freedom to Speak Up Arrangements Task & Finish Group Ownership moving to DWOD	Extended from 31.07.22 to 31.03.23. Extended to 31.05.23	Pushed out date in terms of project plans and impact of Industrial Action. 21.3 The task and finish group has completed its work and the project is now going to be handed to DWOD as SRO for the work.
6. Strengthen Freedom to Speak Up Arrangements policy and advice	Deputy Director of Workforce and OD	31.05.23	Ongoing
7. Create a Manager and Staff training plan for Freedom to Speak Up Arrangements	Deputy Director of Workforce and OD	31.05.23	Ongoing
8. Accountability meetings with senior ops managers	Deputy Director of Workforce & OD	30.09.22 Complete and ongoing	Underway, conversations re sickness absence well established and continuing
9. Attendance Management training for managers	Deputy Director of Workforce & OD	31.12.22 Complete and BAU	Underway and ongoing – now BAU 1.11.22
10.PADR review including wellness questions	Assistant Director – Inclusion, Culture and Wellbeing	Complete	Complete. New PADR distributed October 22.
11.Restart the Health and Wellbeing Steering Group	Assistant Director – Inclusion, Culture and Wellbeing	Complete	Complete – group started 17.10.22 and will meet quarterly.

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence			Date of Review:	21/03/2023	TREND	20 (4x5)
				Date of Next Review:	21/04/2023	➡	

IF the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations	**THEN** there is a risk of a loss of stakeholder confidence in the Trust	**RESULTING IN** damage to reputation and increased external scrutiny		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	4	5	20
			Target	3	5	15

IMTP Deliverable Numbers: 2,18, 26, 34, 38

EXECUTIVE OWNER	Director of Partnerships and Engagement	ASSURANCE COMMITTEE	People and Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Regular engagement with senior stakeholders e.g. Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders	1. Agendas, minutes and documents of engagement events
2. Challenging of media reports to ensure accuracy	2. Programme of daily media engagement
3. Media liaison to ensure relationships developed with key media stakeholders	3. Programme of daily media engagement
4. Engagement Framework approved by the Board July 2022	4. Issues of reputation monitored at EMT via weekly Forward Look item – minuted meetings and action logs.
5. Engagement Framework Delivery Plan approved by the Board January 2023	5. The Director of Partnerships and the Head of Strategy are working closely with colleagues from PWC to inform further detail regarding future engagement including stakeholder analysis, case for change etc. Routine stakeholder and staff engagement continues, including the recent round of Executive roadshows and WAST Live.
6. Engagement governance and reporting structures are in place	6. Relevant information which impacts on reputation is reported and scrutinised via all internal committees e.g. EMT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs. Outcome of recent reputation audit to be reported through EMT in April and onward, as a minimum, to PCC.
7. Escalation procedure for issues to the Board	7. Minuted meetings, action logs and Board papers

GAPS IN CONTROLS	GAPS IN ASSURANCE
1.	1.
2.	2.
3.	3.
4.	4.
5. The delivery plan is in abeyance pending outcome of the work underway by PWC in relation to the Trust's strategic ambitions.	5.
6.	6.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Submit refreshed Board Engagement Framework to Trust Board for approval	Director of Partnerships & Engagement	26.05.22 Complete	Approved July 2022
2. Report progress on Engagement Framework Delivery Plan to the People and Culture Committee	Director of Partnerships & Engagement	Complete	Considered by January 2023 Trust Board
3. Monitoring internal Quality and Performance of Trust	Executive Management Team Finance and Performance Committee Quality, Safety and Patient Experience Committee People and Culture Committee Audit Committee	31.03.23 Checkpoint Date	
4. Engaging with internal and external stakeholders to develop confidence	CEO & Director of Partnerships & Engagement	31.03.23 Checkpoint Date	
5. Monitoring external factors that may affect the Trust	CEO & Director of Partnerships & Engagement	31.03.23 Checkpoint date	

<table>
<tr><td>Risk ID 139</td><td colspan="2">Failure to deliver our Statutory Financial Duties in accordance with Legislation</td><td>Date of Review:
Date of Next Review:</td><td>12/01/2023
12/02/2023</td><td>TREND
➡</td><td>16 (4x4)</td></tr>
</table>

IF	THEN	RESULTING IN
IF the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)	**THEN** there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	**RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage

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

IMTP Deliverable Numbers: 10, 18, 28, 30, 34. 35, 37,38

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at F&P and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	2.
3. Budget management meetings	3. Diarised dates for budget management meetings
4. Regular financial reporting to ADLT, EFG, EMT, FPC and Trust Board in place	4. Diarised dates for EFG and FPC and monthly reports
5. Welsh government reporting	5.
6. Monthly review of savings targets	6. ADLT monthly review
7. Regular review monitoring and challenge via WAST and CASC quality and delivery meeting with commissioners.	7.
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.	8. Diarised dates for ICMB meetings with regular monthly report
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications	9. Regular PSPP communications (Trust wide) on Siren
10. Forecasting of revenue and capital budgets	10. (a) Monthly monitoring returns to ADLT, EFG, EMT and FPC (b) Reliance on available intelligence to inform future forecasting.
11. Business cases and benefits realisation (both revenue and capital)	11. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, EMT, 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. EASC management meetings. Monthly meetings with EASC and DAG for NEPTS.
	8. Bi-monthly Capital CRL meetings with Trust and WG capital leads

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	12/01/2023	TREND	16 (4x4)
		Date of Next Review:	12/02/2023	➡	

IF the Trust does:	THEN	RESULTING IN
IF the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)	**THEN** there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	**RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage

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

	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
	1-10 External audit reviews
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of formalised service contracts between Commissioner and WAST as a commissioned body	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	31/03/23 – Checkpoint Date	
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/23 – Checkpoint Date	
3. Embed value-based healthcare working through the organisation	Executive Management Team and Value Based Healthcare Group	31/03/23 – Checkpoint Date	
4. WIIN support for procurement, savings and efficiencies	WAST Improvement and Innovation Network group	31/03/23 – Checkpoint Date	
5. Foundational economy, Decommissioning and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/23 – Checkpoint Date	

<table>
<tr><td>Risk ID 245</td><td colspan="2">Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations</td><td>Date of Review:
Date of Next Review:</td><td>14/11/2022
14/12/2022</td><td>TREND
➡</td><td>16 (4x4)</td></tr>
</table>

<table>
<tr><td rowspan="4">IF CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident</td><td rowspan="4">THEN there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities</td><td rowspan="4">RESULTING IN potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)</td><td></td><td>Likelihood</td><td>Consequence</td><td>Score</td></tr>
<tr><td>Inherent</td><td>3</td><td>5</td><td>15</td></tr>
<tr><td>Current</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Target</td><td>2</td><td>4</td><td>8</td></tr>
</table>

IMTP Deliverable Numbers: 1, 5, 9

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Trust Business Continuity Procedure and Incident Response Plan	1. Debrief from significant business continuity incidents which are put into organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years and partial review annually unless there is a major learning point. This is currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
2. National EMS CCC Business Continuity Plan (reviewed in March 2021)	2. Business Continuity Plan is up to date and has been reviewed and is currently waiting sign off. Business continuity exercise undertaken on 9.03.22.
3. Clinical remote working arrangements	3. SOP in place with respect to Clinical Remote Working – this is being reviewed at present moment
4. Single instance CAD allowing virtualisation which enables staff to work anywhere	4. CAD alerts if there are systems issues
5. ITK (Interoperability Toolkit) technology in place which provides connectivity with other UK ambulance Trusts. This is used on a daily basis	5. Monitoring undertaken locally at least weekly
	External Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• If CAD is not functional then any impact of current controls would be negated by need to move physical staff	• Business continuity plan requires increased duties for existing staff as a result of lack of physical accommodation (link to risk 244)

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

Risk ID 458	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding of recurrent costs of commissioning services to deliver the IMTP and/or any additional services	Date of Review: 12/01/2023	TREND	16 (4x4)
		Date of Next Review: 12/02/2023	➡	

IF	THEN	RESULTING IN
IF sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis.	**THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients.	**RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage

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

IMTP Deliverable Numbers: 2, 12, 16, 18, 23, 24, 25, 26, 28,30, 34, 37, 38

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at F&P and a report is submitted bimonthly to Trust Board
2. Financial policies and procedures in place	2.
3. Setting and agreement of recurrent resources	3.
4. Budget management meetings	4. Diarised dates for budget management meetings. If an area is in financial deficit, the meeting would be at least once a month. If the area is in balance or surplus, the meeting would be quarterly.
5. Budget holder training	5. Diarised dates for budget holder training
6. Annual Financial Plan	6. Submission to Trust Board in March annually
7. Regular financial reporting to EFG & FPC in place	7. Diarised dates for EFG and FPC with full financial reports
8. Regular engagement with commissioners of Trust's services	**External** **Management (1st Line of Assurance)** 1. Accountability Officer letter to Welsh Government e.g. November 2021 3 and 8 EASC management meetings. Monthly meetings with EASC and DAG meetings for NEPTS. Meetings are diarised 9. Monthly monitoring returns
9. Welsh Government reporting on a monthly basis	**Independent Assurance (3rd Line of Assurance)** 2. Internal Audit reviews of financial policies & procedures as part of their audit plan

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of clarity regarding EASC/Welsh Government commitments with respect to recurrent funding	1. Dialogue with EASC and DAG does not always result in recurrent arrangements (outside of WAST control)

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. A formal approach to service change to be developed providing secure recurrent funding with commissioners.	Deputy Director of Finance	31.12.22	
1. Develop a Value Based Healthcare system approach with commissioners. This would mean that funding would flow more seamlessly between organisations and would go some way to mitigating the risk of not receiving recurrent funding.	Deputy Director of Finance	31.12.22	

Risk ID 557	Potential impact on services as a result of Industrial Action			Date of Review:	12/01/2023	TREND	16 (4x4)
				Date of Next Review:	12/02/2023	NEW	

IF trade unions take industrial action in response to the national pay award	THEN this is likely to disrupt our ability to provide a safe, efficient and good quality service in the 6 core areas the business	RESULTING IN potential harm to patients, adverse effect to patient outcomes, increase in SAIs/concerns/coroners cases, negative media reports, and impact on the Trust's corporate reputation

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

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Director of Workforce & Organisational Development	ASSURANCE COMMITTEE	People and Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Detailed planning process in place	1. Industrial action plan agreed and published
2. Significant preparation for industrial action prior to events	2. Documented processes and actions
3. Negotiations with TU officers on derogations	3. Communications and engagement across the organisation
4. Communications with organisation on IA – regular WAST Live Q&As, briefings and updates	
5. IA issues discussed and recorded at EMT and ADLT	
6. ADLT and Managers co-ordinated on picket sites during IA days	
7. Strategic Command arrangements and HR cover for whole of strike period	
8. Lessons learned exercise after each strike day	
9. Engagement with wider network to maximise system preparedness and support	**External** **Independent Assurance (3rd Line of Assurance)**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Need to determine life and limb cover to meet our legal requirements under the Industrial Action Regulations	1. Awaiting outcome of UNISON ballot (Feb 2023)
2. No control or mitigation on TU decisions on derogations	2.
3.	4.
4.	5.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Maximum engagement with TU colleagues	Director of WOD	Ongoing	Daily meetings with relevant TUPs
2. Negotiate the best derogations possible to protect patient safety	Director of WOD	Ongoing	Derogations negotiated for each IA day
3. Consider options for external support if necessary	Director of WOD / CEO	Ongoing	Watching brief
4.			
5.			
6.			

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	23/12/2022	TREND	15 (3x5)
		Date of Next Review:	23/01/2023	⬇	

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
IF there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	**THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	**RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation	Inherent	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers: 1, 7, 9, 12, 16, 17, 24, 25, 26, 33, 35, 38

EXECUTIVE OWNER	Director of Quality and Nursing	**ASSURANCE COMMITTEE**	People and Culture Committee

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1 Systematic review and assessment of Health and Safety arrangements and Governance (All NHS Wales -Health & Safety Management System - HSMS).	1. Assessment criteria set for health and safety management system (HSMS) all Wales system). HSMS approved at ADLT in 2022. ADLT members sponsorship for all 11 management principles.
2. Health & Safety Governance and reporting arrangements – National Health, Safety and Welfare Committee. Reporting into People and Culture Committee. (PCC)	10. Trusts Legislative Compliance Register in place. Assessments to be reviewed in ADLT in January 2023. Monthly, Quarterly and Annual H&S performance reports to ADLT and H&S National Health, Safety and Welfare Committee. • Quarterly performance reports to ADLT, EMT, PCC. • Reports published on H&S webpage. • H&S climate cultural survey developed to determine perception of Trust position against Bradley Curve.
3. Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, - Regulation 7 'Health and Safety Assistance'.	11. The Working Safely team ceased on 31.09.22. The approval of the transformation of the H&S function business case allowed for significant increase into the function which commenced on 03.10.22. This allowed for the new structure to be implemented.
4. Health & Safety Policy and Corporate level Procedures.	12. H&S Policy approved in 2018. Following landing of business case, Policy review underway Q4 2022. Violence and Aggression Policy, Risk Assessment procedure, Display Screen Equipment procedure, Workplace premise audits inspection procedure in place. Control of substances Hazardous to Health (COSHH), New and expectant Mothers Risk Assessment Procedure awaiting approval at ADLT in Jan 2023. Dangerous Substances Explosive Atmospheres (DSEAR) Procedure, Lifting Operations Lifting Equipment / Provision and Use of Workplace Equipment (PUWER) combined Procedure in draft with an expectation of approval during Q1 2023. Lone worker Procedure ongoing- expectation of second draft Q1 2023. Trust wide Hazard register framework in place. Expectation of being presented at ADLT in Q4 2023.
5. Mandatory Health and Safety training for all staff on ESR. Induction training in place for all new operational staff.	13. Quarterly statistics provided by ESR support team and incorporated into Health and Safety' quarterly and annual Performance reports. Induction training compliance held on ESR
6. 2 year rolling programme of scheduled H&S premise audits.	14. Inspections are being undertaken in line with schedule.
7. Risk assessments (including local risk assessments - Covid 19, workplace risk assessments, risk assessments covering EMS and NEPTs activities, operations risk assessments).	15. Workplace risk assessments are undertaken by local management teams, reviewed by H&S team and previously monitored by BCRT. These are being monitored by local operations mangers. Other operational risk assessments and SOPs are held on dedicated Share-point sections. Performance metrics in place.
8. Working Safely Strategic Programme Board (STB) to provide oversight of the Working Safely Action plan. Dynamic Delivery Action Group to continue to undertake actions on the Working Safely Action Plan.	16. Working Safely Action Plan has been agreed and this is being held to account by Strategic Transformation Board. Deliverables are being monitored through the Dynamic Delivery Group meeting. Terms of reference for Dynamic Delivery Group are approved.
9. Rolling programme of IOSH Managing Safely- for Managers- scheduled training programme in place.	17. Attendance and competency figures provided in a quarterly report to ADLT, National Health, Safety and Welfare Committee and People and Culture Committee.
10. IOSH Leading Safely for Directors and Senior Managers training in place.	18. Attendance and figures provided in monthly report to ADLT. Personal safety commitments are being monitored on a quarterly basis

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	23/12/2022	TREND	15 (3x5)
		Date of Next Review:	23/01/2023	⬇	

IF	THEN	RESULTING IN
IF there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	**THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	**RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation

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

11. Board development Day covering Health & Safety Management and Culture Awareness training undertaken in April 2022.	19. Diarised meeting.
12. Health and Safety Management System recognised document approval routes for health and safety documentation.	20. Approved and minuted at ADLT meeting in 2022.
13. IOSH Leading Safely training delivered to majority of Board and Executive Team on 26 July 2022.	21. Compliance metrics held on H&S team database.
14. IOSH Leading Safely additional sessions for new Board /EMT members and ADLT to be scheduled for 2023.	22.
15. Leading Safely, Safety Positive conversations training to be delivered to Board and EMT in March 2023.	23.
16.	24. Internal Audit to be undertaken in Q4 22/23 (controls 1– 10) **(External Independent Assurance (3rd Line of Assurance)**

GAPS IN CONTROLS	GAPS IN ASSURANCE
1.	**1.** Baseline audit for HSMS not to be commenced till Q1 2023 (***being addressed in Action 1)***
2. Subgroups of National H&S and Welfare Committee currently under review. **(being addressed in Action 2)**	2. H&S Climate Cultural survey to be rolled out once political pressures (IA) reduce**.** Expectation of roll out Q4 2023 (***being addressed in Action 3)***
3.	3.
4. The Health and Safety Policy and some procedures are due to be reviewed by the end of Q4 2022 in Q1 2022 (***being addressed in Action 4***)	4. (a) Review of H&S Policy is due at end of Q4 2022 (***being addressed in Action 4)*** (b) Workforce Transformational change will influence content within H&S policy (***being addressed in Action 4)***
5. Poor uptake in statutory and mandatory H&S training ***(being addressed as part of Actions 5)***	5.
6.	6. Two-year Schedule for H&S inspections and visits commenced September 2022. Compliance metrics, themes and trends are to be included within monthly, quarterly and annual performance reports. ***(being addressed as part of Actions 6)***
7.	7. (a) Current copies of risk assessments and SOPs are not available at all stations. ***(being addressed as part of Actions 7)*** (b) Lack of clarification over many SOPs are required until HSMS baseline audit has been completed. ***(being addressed as part of Actions 7)***
8. Operational pressures on service impacting on Working Safely Programme delivery **(being addressed in Action 8)**	8.
9. Staff availability to attend training ***(being addressed in Action 5)***	9. Work ongoing to determine how many Managers require IOSH Manging Safely. ***(being addressed in Action 9)***
10. Effective learning from events to be documented ***(being addressed in Action 8)***	10. Currently there is no structured monitoring process in place to ensure attendance on the IOSH Leading Safely course. ***(being addressed in Action 5)***
11.	11.
12.	12.
13.	13.
14.	14.
15.	15.
16.	16.
17.	17.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Meetings to be scheduled to undertake baseline assessment and feedback to EMT.	Head of Health and Safety	Q1 2023	

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	23/12/2022	TREND	15 (3x5)
		Date of Next Review:	23/01/2023	⬇	

IF there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	THEN there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	RESULTING IN death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation

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

Action	Action Owner	When /Milestone	Progress Notes
2. Meetings to be held with TU partners and AD/Head of H&S to agree arrangements for sub-groups.	Head of Health and Safety	Q4 2022	ToR Developed and presented at National HSW Committee in Q2 2022. Further discussions requested a Charter arrangement. Draft Charter developed and presented in National HSW committee in Q3 2022. Further discussions requested by TU partners.
3. Assessment to be undertaken in Q4 of political pressure to determine viability of conducting culture survey	Head of Health and Safety	Q4 2022	
4. H&S Policy Group meeting to be established and draft policy to be created	Head of Health and Safety	Q4 2022/Q1 2023	Initial meeting held in December 2022 first draft to be presented at Policy Group Meeting in January 2023 for comments from key stakeholders.
5. Quarterly report on training compliance to be presented to ADLT for actioning within respective Directorates	Head of Health and Safety	Q3 2022	Report is a standard section of quarterly H&S performance report to ADLT
6. IT solution being investigated to collate data from inspections to enable trending and monitoring of actions generated	Deputy Head of Health and Safety	Q4 2023	The audit proforma has been migrated onto MS Forms to allow for improved data collection.
7. H&S advisors will liaise with local management teams to identify risk assessments and SOP's in place and ensure visibility on SharePoint	Deputy Head of Health and safety	Q2 2023	
8. Priority Elements of Working Safely Action Plan to be identified and programme schedule presented to STB to ensure sufficient support from Operational Teams. migrate into Annual Health and Safety Improvement Plan.	Head of Health and Safety	Q4 2022	Priority actions for 2023-24 identified as Culture, Manual Handling, Violence and Aggression, Incident investigation training.
9. Review of number of line managers within the Trust to put in place a suitable schedule to roll out training.	Deputy Head of Health and Safety	Q2 2023	Interim schedule in place to address known line managers.
Completed Actions	**Action Owner**	**When /Milestone**	**Progress Notes:**
1. Delivery of the Working Safely Action Plan (WSAP) (Priority top 25)	Head of Health & Safety	31.09.22 Partially completed.	Pump and Prime phase commenced 01.09.21. Closure report for PPP presented to EMT during Q3 2022/23. Working Safely Programme to continue being monitored by STB. Four priorities determined for 2023/24- Violence & Aggression, Culture, Manual Handling and Incident Investigation.
2. IOSH Leading Safely training to be delivered to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22 Partially completed	Training delivered to Board and Executive team on 26.07.22. Further sessions to be scheduled for Q4 2022/2- Q1 2022/23 for new members.
3. WAST Leading Safely Behavioural Audit training to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22 Scheduled	Scheduled for BDD - February 2023.
4. H&S team workforce review (accompanying Business Case forms part of this) (this forms part of WSAP)	Head of Health & Safety	31.03.22 Completed	Completed- Workforce review fully implemented 03.10.22
5. Culture survey to all members of staff (forms part of WSAP)	Head of Health & Safety	30.09.22 Partially completed	Survey developed and to be presented at National H&S Committee on 02.11.22 and SOT in December for feedback. Decision made during Q3 2022/23 to postpone survey unit political pressures ease. Expectation of roll out Q4 2023-Q1 2023/24.
6. A compliance register that describes the requirements of the various Health & Safety legislation that the Trust needs to comply with (part of WSAP)	Deputy Head of H&S	30.06.22 Completed	Compliance Register framework developed Q2 2022.
7. An initial assessment will provide assurance on how we are complying with the legislation.	Deputy Head of H&S	Partially completed Assurance - 0.06.22 Rolling programme of assessments – 31.12.22 (Checkpoint date)	Assessments undertaken. Some outstanding estates assessments scheduled January 2023.

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Date of Review:	06/12/2022	TREND	15 (3x5)
		Date of Next Review:	06/01/2023	→	

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	**THEN** there is a risk of a significant information security incident	**RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Inherent	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers: 7,8,9,10,12, 16,18,21,23, 24,25, 26, 38

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g. CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g. penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
	External **Independent Assurance** NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Not all information security procedures are documented	1. No regular Cyber/Info Security KPIs are reported to senior management committees

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Date of Review:	06/12/2022	TREND	15 (3x5)
		Date of Next Review:	06/01/2023	➡	

IF	THEN	RESULTING IN
IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	**THEN** there is a risk of a significant information security incident	**RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

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

2. Lack of understanding and compliance with policy and procedures by all staff members	*2.* Cyber awareness campaigns could be undertaken more regularly e.g. bi-monthly
3. No organisational information security management system in place	
4. IT Disaster Recovery Plan does not include a cyber response	
5. Departments do not communicate in a timely manner with Digital Services around putting in new processes, new projects and procurement and this has a cyber security, information governance and resource impact	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1.Establish Cyber and Information Security KPIs	Director of Digital Services	31.12.22	Draft KPIs have been agreed and produced for quarterly reporting. Q1 and Q2 are currently being reviewed within ICT prior to wider circulation.
2.Discuss how cyber risk is reviewed and frequency of review	Director of Digital Services	28/10/22 Close – now Business as Usual	a. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources. b. The corporate cyber risk assessment will be reviewed monthly at the Digital Leadership Group informed by the threat and intelligence monitoring and national strategic trends.
3.Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	28/10/22 Complete	The Trust has run two exercise Joshua & Joshua 2 to test departments readiness
4.Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 - Ongoing	Exercise reports being drafted
5.Formalise Cyber Incident Response Plan	Head of ICT	31.12.22 – Checkpoint Date	Ongoing
6.Implement Meta Compliance Policy Solution	Senior ICT Security Specialist	31.12.22 – Checkpoint Date	Ongoing

<table>
<tr><td>Risk ID 543</td><td colspan="2">Major disruptive incident resulting in a loss of critical IT systems</td><td colspan="2">Date of Review:</td><td>06/01/2022</td><td>TREND</td><td rowspan="2">15 (3x5)</td></tr>
<tr><td></td><td colspan="2"></td><td colspan="2">Date of Next Review:</td><td>06/01/2023</td><td>➡</td></tr>
</table>

<table>
<tr><td rowspan="4">IF there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems</td><td rowspan="4">THEN there is a risk of a loss of critical IT systems</td><td rowspan="4">RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life</td><td></td><td>Likelihood</td><td>Consequence</td><td>Score</td></tr>
<tr><td>Inherent</td><td>4</td><td>5</td><td>20</td></tr>
<tr><td>Current</td><td>3</td><td>5</td><td>15</td></tr>
<tr><td>Target</td><td>2</td><td>5</td><td>10</td></tr>
</table>

IMTP Deliverable Numbers:

<table>
<tr><td>EXECUTIVE OWNER</td><td>Director of Digital Services</td><td>ASSURANCE COMMITTEE</td><td>Finance and Performance Committee</td></tr>
<tr><td colspan="2">CONTROLS</td><td colspan="2">ASSURANCES</td></tr>
<tr><td colspan="2"></td><td colspan="2">Internal
Management (1st Line of Assurance)</td></tr>
<tr><td colspan="2">1. Trust Incident Response Plan and Department Business Continuity Plans</td><td colspan="2">1. Full review of Incident Response plan every 3 years and partial review annually unless there is a major learning point. Annual schedule of testing of BCPs.</td></tr>
<tr><td colspan="2">2. IT Disaster Recovery Plan</td><td colspan="2">2. Recent ICT tabletop exercise undertaken</td></tr>
<tr><td colspan="2">3. Recovery/contingency plans for critical systems</td><td colspan="2">3. Reports from tabletop exercises</td></tr>
<tr><td colspan="2">4. Service management processes in place</td><td colspan="2">4. Documented and approved service management processes in place</td></tr>
<tr><td colspan="2">5. Incident Management Policy, Procedure and Process</td><td colspan="2">5. Incident Policy and Procedure put in place in February 2022. This would be required annually and if there is a system change, the review would be earlier</td></tr>
<tr><td colspan="2">6. Regular data back ups</td><td colspan="2">6. Daily report on status of backup and fully automated process. Log kept of where restores are undertaken</td></tr>
<tr><td colspan="2">7. Resilient and high availability ICT infrastructure in place</td><td colspan="2">7.</td></tr>
<tr><td colspan="2">8. Robust security architecture and protocols</td><td colspan="2">8.</td></tr>
<tr><td colspan="2">9. Diverse IT network (both data and voice) delivery at key operational sites</td><td colspan="2">9.</td></tr>
<tr><td colspan="2">10. Regular routine maintenance and patching</td><td colspan="2">10.</td></tr>
<tr><td colspan="2">11. Environmental controls</td><td colspan="2">11.</td></tr>
<tr><td colspan="2">12. Intelligence gathered from suppliers with respect to future tool sets and enhancements</td><td colspan="2">12. Via email and webinars</td></tr>
<tr><td colspan="2"></td><td colspan="2">External
Independent Assurance
• 2021_16 Internal Audit review of IM&T Control Assessment – baseline exercise
• 2021_19 Internal Audit review of ICT Disaster Recovery – Limited Assurance
• NIS Directive internal audit report 2022 – Reasonable Assurance (covering controls 1-12)</td></tr>
<tr><td colspan="2">GAPS IN CONTROLS</td><td colspan="2">GAPS IN ASSURANCE</td></tr>
<tr><td colspan="2">Non identified</td><td colspan="2">Undertaking Cyber Essentials assessment</td></tr>
</table>

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	31.12.22 Checkpoint date	
2. Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 Checkpoint date	
3. Cyber Essentials assessment to be completed	Head of ICT	31.12.22 Checkpoint date	

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	Date of Review:	13/01/2023	TREND	15 (3x5)
		Date of Next Review:	13/02/2023	➡	

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

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

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Director of Workforce & OD	ASSURANCE COMMITTEE	People & Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Health and wellbeing strategy in place and shared across the Trust.	1. Review undertaken of the Health and Wellbeing Strategy by Assistant Director annually.
2. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme	2. Regular review meetings with all external providers to ensure they meet requirements of the SLA contracts. Regular management information received so that trends can be monitored.
3. Self-referrals or managerial referrals to Occupational Health	3. Regular reports submitted by Occupational Health team to WOD Business Meetings for monitoring.
4. Wellbeing support and training for line managers	4. Diarised meetings, webinars and workshops in place through a rolling programme.
5. Development of range of wellbeing resources for staff and line manager	5. Tools are available on WAST intranet. Occupational Health and Wellbeing teams visit stations, A&E , CCCs and other locations regularly where operational staff are based to promote the occupational health and wellbeing offer.
6. Peer support network forum	6. Agendas and minutes of meetings produced for each meeting.
7. WAST Keep Talking (mental health portal)	7. Available on intranet for staff to access easily.
8. TRiM	8. TRiM Coordinator has regular dialogue with TRiM managers and practitioners. Project plan and training schedule in place. Information in TRim Teams folder.
9. Coaching and mentoring framework	9. Information on intranet on Learning launch pad available to all staff.
10. Acting on results of staff surveys relating to staff experience	10. Each Directorate has developed their own action plan to address staff surveys.
11. HSE stress risk assessments	11. Undertaken by managers and advice is provided on how to use them by Occupational Health team.
12. KPIs are reported monthly to WOD regarding Occupational Health and Wellbeing activity	12. Received at WOD Business Meetings monthly.
13. Wellbeing drop-in sessions for CCC and 111 staff	13. Diarised sessions in place as part of the programme.
14. Fast track physiotherapy	14. Regular review meetings with physiotherapy provider and monthly monitoring information received at WOD Business meetings.
15. Specialist trauma counselling service	15. Same as 15.
16. Regular psycho-educational sessions with managers and staff	16. Diarised sessions
17. Compassionate leadership training sessions	17. Same as 17 in place as part of the programme.
18. Chaplaincy programme	18. Training plan and minutes of meetings produced quarterly for the Wellbeing Team – to be reviewed.
19. Occupational Health team inclusion in sickness and absence meetings	19. Diarised meetings in place.
	External **Independent Assurance** Audit Wales – Taking Care of the Carers report in October 2021
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
	4. Reporting on wellbeing training take up
11. Need to increase the education and communication with managers about stress risk assessments	• Lack of awareness about staff wellbeing services
	• Effects of REAP 4 affecting the ability of staff to engage with staff health and wellbeing services

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

<table>
<tr><td>Risk ID 558</td><td colspan="3">Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences</td><td>Date of Review:
Date of Next Review:</td><td colspan="2">13/01/2023
13/02/2023</td><td>TREND
➡</td><td>15
(3x5)</td></tr>
<tr><td colspan="2">IF significant internal and external system pressures continue</td><td>THEN there is a risk of a significant deterioration in staff health and wellbeing within WAST</td><td>RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm</td><td colspan="5">

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

</td></tr>
<tr><td colspan="3">1. Restart the Health and Wellbeing Steering Group (link to risk 160)</td><td>Assistant Director – Inclusion, Culture and Wellbeing</td><td>Completed</td><td colspan="4">First meeting was on 17/10/2022. This however does not yet bring down the score of the risk as the Steering Group meeting was to re-establish a way forward. Next meeting to be scheduled within 2 months.</td></tr>
<tr><td colspan="3">2. Increase the education and communication with managers about stress risk assessments</td><td>Head of Health & Safety</td><td>Completed</td><td colspan="4">This is part of the IOSH Managing Safety Training BAU. OH to undertake workshops with CCC managers – dates to be confirmed this week.</td></tr>
</table>

Risk ID 100	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	12/01/2023	TREND	12 (3x4)
		Date of Next Review:	10/03/2023	➡	

IF WAST fails to persuade EASC/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: 2, 3, 4, 6, 11, 14, 29, 34

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

CONTROLS	ASSURANCES
	Internal & External **Management (1st Line of Assurance)**
1. EASC/WAST Forward Plan for EMS and NEPTS in place and monitored at EASC meetings	1. Minutes of meetings and a standard agenda item
2. EASC and its 2 sub-committees established as a forum to discuss WAST's strategy	2. Minutes of meetings and a standard agenda item
3. Weekly catch up between CASC/CEO	3. Meetings are diarised every week
4. Collaboration between EASC and WAST on specific projects e.g. Amber Review, EMS Operational Transformation Programme, Ambulance Care Programme	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
5. Monthly CASC Quality and Delivery Meeting established	5. Formal meeting with agendas, minutes and action logs available.
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 stakeholders fortnightly
7. Programme structure has been established for 'inverting the triangles' including EASC	7. It exists and has had its first meeting
	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. EASC meetings focus largely on EMS and cursory note of NEPTS	1. Health Boards are not sending Patient Safety Incidents that are National Reportable Incidents to the Delivery Unit (identified within a Delivery Unit audit)
2. Governance coordination between NCCU and WAST to be improved.	2. Identified need for a governance meeting between NCCU and WAST to manage the overall commissioner/provider interface
3.	7. This is a new structure that has been established and is yet to be embedded and tested for assurance
Xx WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	
Xx Funding does not flow in a manner to balance demand with capacity (this is outside of WAST's control)	

	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence EASC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	31.12.22 – Checkpoint Date	30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23. 12/01/23 Recurrent funding for the +100 not secure.
2. Agree and influence EASC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	31.12.22 – Checkpoint Date	30.09.22 4 hour handover backstop agreed and -25% reduction in handover from October 2021 baseline. 12/01/23 There has been a significant worsening picture
3. Increased understanding of NEPTS by EASC	Director of Strategy Planning and Performance	31.12.22 – Checkpoint Date	30.09.22 "Focus on" session at May 2022 EASC and NCCU represented on Ambulance Care Programme Board. 12/01/23 F&P Deep Dive made available to NCCU.
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	31.12.22 – Checkpoint Date	30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue.
5. Utilising the engagement framework to engage with the stakeholders	Director of Partnerships & Engagement AD Planning & Transformation	31.12.22 Checkpoint date	30.09.22 Significant engagement through roster review briefings.

Risk ID 100	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	12/01/2023	TREND	12 (3x4)
		Date of Next Review:	10/03/2023	➡	

IF WAST fails to persuade EASC/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

			12/01/23 Engagement on roster review largely concluded, with some political interest continuing in a few areas.

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	12/01/2023	TREND	12 (4x3)
		Date of Next Review:	12/03/2023	➡	

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: 2, 4, 6, 11, 20, 34

EXECUTIVE OWNER	Director of Workforce and Organisational Development	ASSURANCE COMMITTEE	People & Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Agreed (Refreshed) TU Facilities Agreement developed in partnership	1. Agreed document which states governance arrangements and the criteria for time off for TU activity etc.
2. Go Together Go Far (GTGF) statement and CEO/TU Partners statement	2. Both parties refer to the documents and are signed up/committed to it
3. IPA Workshops	3. Meetings completed with participation from TUs and senior managers. Attendance lists are available
4. Trade Union representation at Trust Board, Committees	4. Committee or Board ask TU representative for feedback or whether they have been consulted. Big issues items progress as planned as a result of TU partner buy in
5. Monthly Informal Lead TU representatives and Chief Executive meetings	5. Diarised meetings
6. Staff representative management in Task & Finish Groups	6. Good attendance and commitment is observed at the meetings. TU partners listed as members in terms of reference
7. WASPT re-established post stand down of cell structure post pandemic	7. Diarised meetings with a formal agenda. Any business needed to be discussed is included in the agenda. Good attendance and commitment observed at meetings.
8. Local Co-Op Forums, and informal monthly meetings between TUs and Senior Operations Team	8. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings
9. Quarterly Report on TU activity to People and Culture Committee	9. Report at every P& C committee meeting regarding activities TUPs involved with which is noted. Whenever Partnerships are discussed, the value of these is formally minuted in the Board and Committee minutes
	External Not applicable

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Need to move back to business-as-usual footing	None identified
2. Facility to manage situations where there is a failure to agree, to avoid grievance and disputes from occurring	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Develop an action plan from the recommendations of the ACAS report	Deputy Director of Workforce & Organisational Development	Completed 12/01/23	Action Plan for delivery created and shared with TU Secretary for feedback from TUPs
2. Agree the ToR for refreshed Partnership Forum meeting and move back to a business-as-usual footing	Deputy Director of Workforce & Organisational Development	Completed 12/01/23	WASPT re-established. Third meeting scheduled T&F group undertaking work on the engagement model below WASPT through SLT and SOT is in progress with TU engagement. TU cell stood down.
3. Proposed 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	Deputy Director of Workforce & Organisational Development	Completed 12/01/23	Rearranged date 24.08.22 due to COVID in ACAS facilitators. First ACAS sessions delivered in June. Joint ACAS session with TUPs and Senior Team delivered on 24.08.22. Awaiting report from ACAS advised they are finalising by 23.09 and will forward week of 26th Sept. Draft plan in development to capture actions from the

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	12/01/2023	TREND	12 (4x3)
		Date of Next Review:	12/03/2023	➡	

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

			meeting. Actions from the ACAS recommendations will be added on receipt. Report received in October. Action plan developed and shared with TUs. Implementation underway
4. Minutes of formal Partnership Forum should be reported to PCC or Board in future (return to BAU).	Deputy Director of Workforce & Organisational Development	Completed 12/01/23	WASPT feeding into PCC

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	12/01/2023	TREND	12 (3x4)
		Date of Next Review:	10/03/2023	→	

IF	THEN	RESULTING IN
IF there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme	**THEN** there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters	**RESULTING IN** potential patient harm, deterioration in staff wellbeing and reputational damage

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

IMTP Deliverable Numbers: 3, 7, 17, 18, 19, 20, 27

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Implementation Programme Board in place – meetings held every 3 weeks with the DASC and TU reps on the membership	1. Minutes and papers of Implementation Programme Board
2. Executive sponsor and Senior Responsible Owner (SRO) for programme in place	2. Project Initiation Document (PID) detailing structure and minutes of Implementation Programme Board
3. Programme Manager and Programme support office in place (for delivery of the programme)	3. Same as 2
4. Programme risk register	4. Highlight reports showing key risks reported to STB every 6 weeks
5. Assurance meetings held with Strategic Transformation Board (STB) every 6 weeks and with CEO every 3 weeks	5. Highlight reports presented to STB every 6 weeks
6. Programme budget in place (including additional £3m funding for 22/23)	6. Programme budget monitoring report is provided to the Implementation Programme Board – every 6 weeks and letter received from CASC on £3m funding for 22/23
7. Programme documentation and reporting is in place to Programme Board every 3 weeks and STB receives highlight report	7. PID and Programme Plan Summary kept up to date. PID is presented to the STB if there is a significant change in the programme deliverables. Programme Plan Summary reported to the Implementation Programme Board every 3 weeks.
8. Regular engagement with the Commissioner and Trade Unions and representation	8. Commissioner and TU participation at the Implementation Programme Board
9. Management of external stakeholder and political concerns	9. Communications and Engagement Plan sets out WAST's arrangements for engagement with stakeholders
10. Secured specialist consultancy to support decision making	10. Reports and contractual compliance
11.	**External** **Management (1st Line of Assurance)**
	a. Deputy Ambulance Services Commissioner sits on the Implementation Programme Board
	b. Emergency Ambulance Service Committee Management Group receives a highlight report every two months
	c. EASC receives an update every 2 months on the programme as part of the WAST Provider Report

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Current controls on workforce buy in are not sufficient due to changes in working practices	1. Project Initiation Document (PID) needs to be updated to reflect 22/23 budget position
2. System pressures – patient handover delays at hospitals (link to risks 223 & 224)	2. No prompts from STB for programme PID or risk register updates

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Increase in engagement on the specifics of change through facilitation mechanisms	Assistant Director – Commissioning & Performance	31.12.22 – Checkpoint Date	30.09.22 Significant engagement through roster review project. 12/01/23 Largely complete.
2. More capacity requested (transition plan)	Assistant Director of Planning & Transformation	31.12.22 – Checkpoint Date	30.09.22 Transition plan not funded, but +100 FTE agreed. 12/01/23 Recurrent funding not secure.
3. Engage with key stakeholders to reduce handover delays	CASC	31.12.22 – Checkpoint Date	30.09.22 Reduction commitments agreed, but trend is still upwards. 12/01/23 Extreme and upward trend.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	12/01/2023	TREND	12 (3x4)
		Date of Next Review:	10/03/2023	➡	

IF there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme	THEN there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters	RESULTING IN potential patient harm, deterioration in staff wellbeing and reputational damage		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	3	4	12
			Target	2	4	8

Action	Owner	Date	Progress
4. Reduce abstractions in particular sickness absence	Deputy Director of Workforce & OD	31.12.22 – Checkpoint Date	30.09.22 Sickness absence reducing, but abstractions high linked to sickness, but also training abstraction linked to the +100. 12/01/23 Abstractions have reduced, but still very high. Sickness is reducing and on trend to achieving the 10% Mar-23 target. High abstractions linked to internal movements caused by internal recruitment.
5. Engage with Assistant Director of Planning and Transformation on process for PID updates	Assistant Director – Commissioning & Performance	31.12.22 Checkpoint Date	30.09.22 HoT recruited and now started. Initial contact made with HoT. PID is up to date. 12/01/23 PID has been further updated but requires sign off by the SRO and STB.

<table>
<tr><td>Risk ID 424</td><td colspan="3">Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)</td><td>Date of Review:
Date of Next Review:</td><td>13/01/2023
01/04/2023</td><td>TREND
➡</td><td>12 (3x4)</td></tr>
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IF	THEN	RESULTING IN
IF resources are not forthcoming within the funding envelope available to WAST (link to risk 139)	**THEN** there is a risk that there is insufficient capacity to deliver the IMTP	**RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	1	4	4

IMTP Deliverable Numbers: 5,9,10, 17, 28

EXECUTIVE OWNER	Director of Strategy Planning & Performance	**ASSURANCE COMMITTEE**	Strategic Transformation Board and Finance and Performance Committee

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Prioritisation of IMTP deliverables	1. Prioritisation detailed in IMTP and reviewed and agreed at Strategic Transformation Board
2. Financial policy and procedures	2.
3. Governance and reporting structures e.g. Strategic Transformation Board (STB)	3. IMTP sets out delivery structures and meeting minutes are available
4. Assurance meetings with Welsh Government and Commissioners	4. Agendas, minutes and slide decks available
5. Transformation Support Office (TSO) which supports the major delivery programmes	5. Paper on TSO to Strategic Transformation Board
6. Project and programme management framework	6. PowerPoint pack detailing PPM
7. Regular engagement with key stakeholders	7. Stakeholder Engagement Framework
	Independent Assurance (3rd Line of Assurance) 2. Subject to Internal Audit
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Project and programme management (PPM) framework to be reviewed	1. PPM needs to be reviewed and approved through STB
2. Head of Transformation vacancy	2. Benefits have not been fully linked to benefits realisation
3. Lack of a commercial contractual relationship with Commissioners (link to risk 458)	

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Recruit a Head of Transformation	Assistant Director of Planning	30.09.22 complete	Recruited 02.08.22 in post on 01.11.22
2. Review the PPM	Head of Transformation	Extended from 31.03.23 – To 31.03.23 Checkpoint Date	Currently (January 2023) working through delivery structures for 2023-26 which will inform the PPM review – changed checkpoint date to 31.06.23
2. Develop Benefits Realisation plans in line with Quality and Performance Management framework	Assistant Director of Planning/Assistant Director, Commissioning & Performance	Extended from 30.09.22 – To 31.03.23	Reviewed action and extended checkpoint date further as approach being developed for next iteration of IMTP. Work ongoing.

Risk ID 424	Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	13/01/2023	TREND	12 (3x4)
		Date of Next Review:	01/04/2023	➡	

IF resources are not forthcoming within the funding envelope available to WAST (link to risk 139)	**THEN** there is a risk that there is insufficient capacity to deliver the IMTP	**RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	1	4	4

		Checkpoint Date – T0 31.06.23 checkpoint date	
3. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Deputy Director of Finance	31.12.22 – checkpoint date 31.03.23	Extend checkpoint date to 31.03.2023 on basis of new financial allocations for 2023 to be worked through with Commissioner

IMTP Deliverable Key

No.	IMTP Deliverable
1	We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19
2	We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum
3	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)
4	We will work with partners to promote and expand use of 111 across Wales
5	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team
6	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations
7	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
8	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice
9	We will increase and balance response capacity and capability across urban and rural area of Wales
10	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients
11	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover
12	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
13	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand
14	We will develop and implement with partners an-All Wales transfer and discharge service
15	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery
16	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
17	We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance
18	We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment
19	We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment
20	We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented
21	We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app)
22	Improved signposting to the most appropriate service
23	Improved digital tools and services to empower our teams to do their best
24	We will use modern technology to reduce repeat tasks and improve processes
25	Standardised information architecture and common approach to data and analytics across the organisation
26	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation
27	Improved resilience, flexibility and interoperability for the 999-call platform
28	We will provide an improved financial plan to support our ambitions
29	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation
30	We will deliver the Estates Strategic Outline Plan
31	We will implement the Environmental and Sustainability Strategy
32	Deliver the Fleet SOP
33	We will secure and implement Quality Management and control systems
No.	**IMTP Deliverable**
34	We will transform the way we work and engage with people
35	We will revisit and implement the Public Health Plan
36	We will implement the Clinical Strategy to support developments across our service ambitions
37	We will deliver a values-based approach
38	We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance