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:	11/04/2025	TREND	25 (5x5)
		Date of Next Review:	11/05/2025	➡	

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

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

IMTP Deliverable Numbers: 1, 2, 3, 4, 5, 6, 7, 8, 10, 14, 15, 20, 22, 24, 25, 27

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

Risk Commentary Q1 2024/2025

The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death because of the Trust not being able to reach patients in the community. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. **Handover lost hours in February were 18,816 and in March 21,854.**

The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners ackno

wledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.

Improvement actions led by Welsh Government and system partners include: -

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 reduces 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)

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. 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). V1.3 has been reviewed, updated and released (August 2024).
3. Resource Escalation Action Plan (REAP)	3. 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. REAP has undergone an annual review with **v5.1 released in January 2025**
4. 24/7 Operational Delivery Unit (ODU)	4. 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.
5. Strategic, Tactical and Operational 24 hour/ 7 day per week system to manage escalation plans	5. Same as 4 - 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. On Call cover is reviewed weekly at SLT Performance Meetings.
6. Limited Alternative Care Pathways in place	6. 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.
7. Consult and Close (previously Hear and Treat)	7. The Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Reported through integrated quality meeting. Whilst Consult and Close is in place, the action to increase compliance is detailed in the action plan.
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	8. WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	11/04/2025	TREND	25 (5x5)
		Date of Next Review:	11/05/2025	➡	

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

	setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. This is part of the IMTP Deliverables 2024-2027.
9. Clinical Safety Plan (CSP)	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The subsequent reduction in the demand is the assurance which is dynamically monitored via ODU. New CSP released 17th December 2024, released to enables the Trust to manage risk more effectively at a system level, ensuring that patients are not unnecessarily directed to EDs (can't send) when they can be safely managed through other pathways. In doing so we help to reduce demand on EDs and therefore hospital handover delays, support a better working environment for staff and ensure improved ambulance availability for those who need them most.
10. Recruitment and deployment of CFRs	10. 11 new onboarding courses for June to December with projection of 110 new CFRs by 3rd December 2024. Currently 400 volunteers supporting 6500 hours every month. Response data indicates that our CFRs are reaching more patients, especially those with life threatening conditions in 8 minutes compared to this time last year. Numbers of CFR's, percentage of contribution to performance a governance framework is in place. Monitoring through AD 1:1's and volunteer highlight report (IMTP).
11. ETA scripting	11. The ETA Dashboard is a tactic that was signed off by ELT. The dashboard supports scripting analysed by comparing with real time data. ETA performance is reviewed weekly at SLT weekly performance meeting. The effect of the ETA scripting results in cancellations of ambulances which is monitored through algorithmic review process.
12. Clinical Contact Centre (CCC) emergency rule	12. Emergency Rule is incorporated into CSP 999 levels.
13. National Risk Huddle	13. 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.
14. Summer/Winter initiatives	14. Monitoring through SLT and STB. Senior Planning Team (SPT) was stood up for the duration of Winter 2023/24. Christmas Planning Meetings established from April 2024 for winter period 2024/2025.
15. CHARU implementation	15. Recruitment of 153 WTE has continued; To lift further, a trial of a rotational model is due to be trialled in Aneurin Bevan Health Board area.
16. Clinical Model and clinical review of code sets	16. Reported through CPAS and DCR Review reporting through CQGG
17. Remote clinical support enabling discharge at scene	17. Strategic Transformation Board – IMTP deliverable; Providing support to the Community Welfare Responders (CWR) initiative and supporting CFRs to discharge at scene with current non conveyance rates for CFRs in excess of 40%
18. 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)	18. Formally documented action plan – actions captured are contained within and monitored via the Mitigating avoidable harm paper from PIP.
19. Information sharing	19. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
20. Completed EMS Roster Review	20. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner. Monitor production against the rosters weekly at performance meeting and that provides a level of UHP as a percentage.
21. Delivered a reduction in the number of multiple vehicle attendances dispatched to red calls	21. This will increase vehicle availability generally across the Trust and is monitored through SLT weekly performance meeting.
22. Transfer of Care	22. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief
23. Virtual Ward – Connect Support Cymru	23. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru with a further extension in place.

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	• Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach and has now completed. • Work ongoing to recruit CWR volunteers with engagement taking place with organisations across Wales. • St John Ambulance Cymru virtual ward now extended to the end of May 2024.
24. ARA – - YGC, Swansea Bay and GUH	24. ARA in GUH finished 31st March 2024. Holding area in Swansea and YGC remains ongoing.
25. 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 Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. 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. 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.	25. 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.
26. Undertake the next 5-year strategic EMS Demand and Capacity review (the 2019 version will run out this year – 2024)	Review has been undertaken and has been reported to closed FPC committee July 2024 and Trist Board July 2024. This review details the level of resourcing required in different handover lost hour scenarios with different ways to respond to it e.g. traditional model or evolved CRN.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1.1 Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4-hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morriston hospital has increased focus on handover delays with external partners and across the media. Some plans are in train (detailed in actions) following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter. 1.2 March25 - **NHS exec has established a Handover Improvement Group, the terms of reference and scope of work has yet to be defined and is being led by the Director of Operations, NHS Exec.**
2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow	
3. Local delivery units mirroring WAST ODU	
4. Handover delays link to risk 224	
5. 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 12 months there is a low confidence in attaining this.	5. The majority of Health Boards have failed to deliver on this ambition; With the exception of Cardiff and Vale University Health Board, the remaining 5 Health Boards with acute Trusts that were required to deliver on this target, have failed to do so.
6. Handover Improvement Plans agreed between WAST and Health Boards	6. Performance targets for Handover with Health Boards have been introduced by the commissioner.
7. Access to Same Day Emergency Care (SDEC) for paramedic referrals	7. This forms part of the handover improvement plans in place with Health Boards; however, assurance is limited given that the uptake is low (less than 1% of total demand). There is an inconsistency in approach from Health Boards on eligibility and availability; The national Once for Wales acceptance criteria has not been uniformly deployed by Health Bards across Wales.
8. Mental Health users connecting via the 999 system to 111 press 2 services. Discrepancies in pathway between 111 and CSD – point of entry influences pathway.	
9. Volunteer Alternative Responder Scheme (VARS)	9. Live from June 2024 with further scheme due to rollout across Wales.

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10. There is currently no JCC implementation plan associated with the 2023 Demand and Capacity Review	10. The requirements for a funded implementation plan for the review i.e. resource envelopes change from the JCC. The review is being reported to JCC board development session in August 2024 and is expected to go to JCC committee later this year. The expectation is that the 2025/26 commission intentions will respond to the review.

Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST

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 - Superseded	
3. 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]	Director of Paramedicine / Director of People & Culture	Superseded	16/01/2025 APP growth has been steady throughout the year, focussing mainly on CTM and AB Health boards which have had the lowest APP numbers. We are on track to reach our recruitment target for the year 120.7 FTE. A standardised training route including clinical placements in Primary Care has been supported for all trainees and the development of APP Nav models which are co-located in each Health board have been prioritised to support the UCRS Transformation work, with 49 APPs working rotationally in 6 out of 7 Health boards in an APP Nav model. Despite successful funding bids to support APP growth from external sources, we continue to link closely with strategic partners to showcase the impact of APPs in WAST and develop partnership working across the Health Board regions. WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. May 24 - Initial bid unsuccessful however an action within the new IMTP to grow our APP workforce by up to 40 per year for the next 3 years. Updates will progress through the IMTP within quarters. Milestone changed from March 2024 to June 2024.

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	Likelihood	Consequence	Score
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4. APP recruitment	Assistant Director of Operations	**August 2025**	Aug 24 – Modelling of APP growth trajectory to be modelled through the APP recruitment Steering Group for approval at ELT. Numbers to be confirmed at point of approval. **March 25 – Following last recruitment event. Decisions between clinical and operations teams ensuring collaboration between the two directorates for future recruitment and to strategically identify areas of recruitment.**
5. IMTP Deliverables 2027-2027	Assistant Director of Integrated Care (with SRO through CMT Board)	**Closed**	**March25 – Last year's IMTP deliverables completed, closed.** Phase 1 for winter May24 – Ops engagement commenced April 2024. Temporary ADO recruited to support winter actions. Plans to deployment between October 2024 and March 2025.
6. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.
7. Connected Support Cymru – is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Assistant Director of Quality Governance	Superseded with the implementation of the new model (ref: Action 5)	Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered in partnership with St John Ambulance Cymru to deliver the CWR element. Initial phase due to conclude in March 2024, further extended to May 2024 due to SJAC funding accommodating extension arrangement. • NHS Charities Together (grant) funding obtained through external application, to develop internal volunteer capacity/volunteer workforce as CWRs. Piloting of the CWR model commenced in Spring 2024, with an expansion of the model in mid-October. Recruitment, onboarding and training continues with aspiration to recruit CWRs across Wales. • The SBRI innovation challenge has supported a phase 2 delivery of the digital ward model: enabling remote clinicians to care for patients in a 'virtual ward' capacity. It is envisioned this will enable patients to reach to right care at the right time, whilst being monitored remotely. The pilot has commenced for care homes in Wales, and a dedicated remote clinician is supporting the initiative generating organisational learning to expand remote care planning role the Trust can provide for the NHS Wales. The pilot initiative will conclude in March 2025. • The work will form part of the RICs workstream from September 2024.
8. Maximise the opportunity from Consult and Close: - Successful resolution without ambulance (double EMS) - Successful resolution without conveying to ED		March 2025	**March25 – Consult and Close continues above 20% on a sustained basis with further work delivered through CMT aimed at maximising C&C opportunities.**

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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

			Trust ambition is to improve Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Consult and Close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead to shorter triage durations, along with increase in staffing, which together will enable more triages to take place, thus increasing the number of successful resolutions without a double EMS ambulance and numbers conveyed to an ED.
9. Palliative Care Paramedic Unit	Assistant Director of Operations	March 2025	**March25 – SLT agreed with ELT noting that palliative care paramedics will be afforded the opportunity to apply for APP positions therefore making palliative care the 3 strands for the APP function. Numbers will be embedded into APP funds (ref: Marie Curie)** 16/01/2025 - At the end of the 3-year pilot, evaluation has been shard via an SBAR in SOT on 14th January and subsequently SLT on 21st January. This may potentially be BAU if approved. Reducing demand via APPs – 15th January Start. 15/04/2024 - 3 Month Health Board funded trial ended. Whilst utilisation was low, the results demonstrated a circa 75% ED avoidance therefore local decision made to extend for a further 2 months, however, opening the trial up to wider community and crew referrals. 21/06/2024 - Unit still ongoing.
10. 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?	CEO	**TBC**	• **March25 – Awaiting report from Audit Wales which will come through Audit Committee.** • 01/10/2024 - The review of the unscheduled care report part 2 (accessing urgent and emergency care) is underway and will come to the committee in November 2024. • Conducted in three phases 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. • Expected outcomes in 2023/24.
11. Royal Glamorgan Early Diagnostic	Executive Director of Operations	**August 2025**	• **March25 - No changes due to system pressures of Cwm Taf Morgannwg, it's been agreed temporarily for CTM to focus on internal processes before progressing further.** • Initial data from Qlik shows that there has been no reduction in N2H times however data received from Health Board show indication of patient benefit to reach earlier diagnostic. Local meetings this month to discuss findings and explore opportunities. • May 24 – No improvement in N2H time. Local management having discussions with Health Board for review and next steps.

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:	11/04/2025	TREND	25 (5x5)
		Date of Next Review:	11/05/2025	➡	

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: 1, 3, 8, 14, 15, 22, 23, 24, 25, 26, 27, 30, 31

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

Risk Commentary Q4 2024/25

- The risk score remains constant at 25 for quarter 2 2024/25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. JCC set a target of 15,000 hours lost by the end of Q2 and 12,000 hours lost by the end of Q3. The handover lost hours in November were 20,993 and December were 25,199. The expectation is that these would have been eradicated by end of 2023/24. Cardiff & Vale UHB has demonstrated material improvement and is a positive outlier when compared to other health boards. Recently, the Welsh Government had re-iterated to Health Boards that the reduction in long handovers is a priority for this year with an expectation that over 1-hour waits would be reduced by 30% by December 2024. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, coronial enquiries and redress / claims. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust received the first Prevention of Future Deaths Report in February 2024 relating to pressure damage, which is a joint Report with Swansea Bay University Health Board. On 22.02.2024 a Prevention of Future Deaths Report was sent solely to the Minister for Health and Social Services, Welsh Government in respect of delays responding to a patient in community which also references handover of care delays. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. Given the long-standing nature of the system pressures and long handover times, we have commenced work to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and, Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for our ambulance trolleys.

Improvement actions led by Welsh Government and system partners include:

a) 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 – (Welsh Government) ***by the end of April 2025***
b) National Six Goals programme for Urgent and Emergency Care: 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 is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance.
c) The Trust also has a presence on all the individual goal boards. The Trust has been asked to provide a presentation on its offer to the system at the next Six Goals Programme Board (24 January 2024).
d) NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) ***revised to March 2023/24.***
e) Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000.
f) 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? (Audit Wales)
g) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer) – paused. Health boards have previously been required to develop handover reduction action plans, which are monitored at their Integrated Quality, Planning & Delivery (IQPD) meetings by Welsh Government. Handover is also discussed at the Integrated Commissioning Action Plan (ICAP) meetings (currently paused as commissioning arrangements transition into the new Joint Commissioning Committee) which are held monthly between the CASC, the Trust and each Health Board.

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 Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. 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. Increased collaboration through the Serious Case Incident Forum (SCIF), Mortality Review Group, and the Learning from Events Meeting (LFEM). These platforms emphasise joint investigations, shared learning, and actionable insights to prevent future harm and improve patient outcomes.
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	2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Agreement was 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. An event reviewing the effectiveness of the Joint Investigation Framework is currently being scoped nationally.

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:	11/04/2025	TREND	25 (5x5)
		Date of Next Review:	11/05/2025	➡	

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

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.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department 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.	5. Monthly Integrated Quality and Performance Report and WAST is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance. The Trust also has a presence on all the individual goal boards.
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. REAP has undergone an annual review with v4.1 released in November 2023.
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 and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST
9. 24/7 operational oversight by ODU with dynamic Clinical Safety Plan 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. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.
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. On Call cover is reviewed weekly at SLT Performance Meetings.
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.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.	12. Monthly Integrated Quality and Performance Report (April 2024 overall 82% - Safeguarding is 78% and dementia awareness remains over 91%).
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 JCC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Joint Commissioning Committee (JCC); 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	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 May 2024) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

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:	11/04/2025	TREND	25 (5x5)
		Date of Next Review:	11/05/2025	➡	

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

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."	
16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023.	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 May 2024 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources. From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical & Quality Governance Group.
17. Clinical Support Desk First in place	17.
18. Summer/Winter initiatives	18. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2024/25.
	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), the Joint Commissioning Committee (JCC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with 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 JCC.
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
	4. Internal Audit Report (April 2024) Serious Incidents: Joint Investigation Framework (WAST internal processes) provided 'Reasonable Assurance' with low to moderate impact on residual risk exposure until resolved. Improvement actions are monitored via the Audit Tracker.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures – recruitment in line with Organisational Change Process is progressing with full establishment expected by July 2024.	
2.	1. Implementation of the revised Joint Investigation process with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 56 overdue nationally reportable incident (NRI) investigations, with 63 NRIs open in total. Shared system learning from the Joint Investigation Framework is currently limited with no new learning identified to date.
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.	2. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In October 2023, 23,232 hours were lost with 1,888 +4 hour delayed patient handovers.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS.	3. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5. Variation pan Wales / England as position not implemented across all emergency departments.	4. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.
6. 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.	5. HIW approve and sign off WAST elements of recommendations.

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

External Gaps in Assurance

1. Lack of escalation and response to AQIs by the wider urgent care system and regulators

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	TBC – Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. 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	Q3 2024/25	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available and access for the Patient safety Team is being explored. Work on-going with Health Informatics regarding patient safety and health board dashboards capacity in Health Informatics impacting and dates revised. • Local dashboards have been developed but requiring manual data extraction
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners.	Director of Paramedicine	Q4 2024/25	• The Trust uplifted its APP establishment by a further 15.7 FTEs in • 2023/24 (funded through internal movements). For 2024/25 the Trust • is funding a further uplift of 32 APPs (additional funding, not internal • movements). • The above uplifts will increase the APP establishment to 120.7 FTEs.
5. Overnight falls service extension and future modelling	Executive Director of Quality & Nursing	31.09.2024	•Overnight falls service extension and future modelling • Night Car Scheme extension agreed to 31 September 2024 (2 regional resources) • Utilisation rates continue to be monitored: • Nighttime utilisation: - Q2 65% Q3 64% Q4 to date 64% April 2024 - 67% • Daytime utilisation: - Q2 57% Q3 56% Q4 to date 58% April 2024 – 54% • Combined day and night Q2-Q3 58% Combined day and night Q4 to date 59% Combined day and night April 2024- 55% There is now also an additional Level1 nighttime resource through RPB and Gwent Resilience Plan ringfenced to ABUHB. AB dedicated level 1 62% for April 2024 The 2023 EMS Demand & Capacity Review has completed its modelling of falls level 1 and level 2 resources. This will now need to be considered further by the Trust, commissioners and health boards. There is an immediate focus on the contract beyond September 2024. The 2023 EMS Demand & Capacity Review will be formally reported to Trust Board in July 2024.
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded. Quality Report	Executive Director of Quality & Nursing	Q4 2024/25	• Monthly updates to progress against actions following the baseline assessment and readiness returns continued. • RL Datix Dashboards and KPIs under development nationally by National Quality & Safety Group.

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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

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Inherent	5	5	25
Current	5	5	25
Target	3	2	6

development underway – mandatory requirement to publish 2024/25 (no fixed date for publication nationally).			• Key policies updated and approved further updates following release of revised Putting Things Right Regulations which is delayed now expected release by Welsh Government in Autumn 2024 therefore timescale amended. Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly. • Still underway
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Executive Director of Quality & Nursing	Q2 2024/25 Extended	• Further meetings arranged with between the Executive Director of Quality & Nursing and Six Goals Programme/WG/. Trust has also approach WG with a smaller ask to facilitate continuation of the LUSCII solution Continued expansion of the Connected Support Cymru initiative, leveraging digital and telehealth platforms. Recruitment efforts for Community Welfare Responders (CWRs) are ongoing, with engagement across Wales to bolster capacity and resilience.
8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	Q2 2024/25	• OCP commenced 25.09.2023 and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by May 2024 (taking notice periods into account). Recruitment is progressing well with multiple applications for each post and some internal promotion opportunities. • Final posts due to be recruited to and in place by July 2024.
9. 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?	CEO	Q2 2024/25	• Conducted in three phases 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. Expected outcomes in 2023/24. • The audit is proceeding. Trust awaiting the outcome. AD Commissioning & Performance has requested an update from Audit Wales. • Audit Wales have confirmed this has been reprofiled into 2024/25.
10. Patient handover actions.	Executive Team	Under review	• Some English ambulance services operate a system whereby handovers are mandated or forced after a certain period e.g. WMAS and LAS. This will be reviewed by the Executive team.
11. Work in progress to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for ambulance trolleys.	Executive Director of Quality & Nursing	Q3 2024/25	• Fundamentals of Care meeting, chaired by the Executive Director of Quality & Nursing held on 08.03.2024.
12. Trust to produce its own six goals plan (Goal 4 links to handover of care)	Executive Director of Strategy, Planning &	?	• Trust to produce its own six goals plan (Goal 4 links to handover of care)
13. Development of the RICS service.	Executive Director of Quality & Nursing	Q4 2024/2025	• Winter Desk and Care Planning Initiatives: • The aim of Care Planning is for clinicians to provide holistic management of a patient's care journey through WAST by carrying out ongoing monitoring where appropriate to ensure patients flow to the most suitable disposition to meet their needs. The aim of Care Planning is for clinicians to provide holistic management of a patient's care journey through WAST by carrying out ongoing monitoring where appropriate to ensure patients flow to the most suitable disposition to meet their needs. • Activation of the Care Planning and Winter Desk initiatives, providing operational oversight and

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

			pre-emptive measures to address seasonal demand surges. These efforts are crucial to sustaining system resilience and minimising patient harm. • Deployment of specialists in respiratory care and pediatrics, addressing critical clinical gaps and improving care pathways. • The remote clinical care leadership is growing, with the addition of two new specialist roles to complement the existing and growing multidisciplinary expert team. The addition of specialist clinicians in remote care for pediatric and respiratory care is a significant step forward in our commitment to enhancing patient care and aligning with our organisational plans to care for more patients in more alternative ways than traditional ambulance responses. • We will welcome a pediatric nurse specialist and a physiotherapist respiratory specialist in early February 2025 and look forward to understanding more about how their wealth of advanced clinical experience and expertise can contribute positively to safe person-centered outcomes for patients who often require the help and assistance of both 999 and NHS 111 Wales. • Ongoing progress in appointing a Learning Disabilities Specialist to further enhance equity and inclusion in care delivery.

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:	11/04/2025	TREND	20 (5x4)
		Date of Next Review:	11/05/2025	➡	

IF	THEN	RESULTING IN
there are high levels of absence e.g., sickness and alternative duties.	there is a risk that there is reduced resource capacity	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: 13, 14, 15, 22, 24, 25, 26

EXECUTIVE OWNER	Director of People	ASSURANCE COMMITTEE	People and Culture Committee

Risk Commentary

Sickness absence remains one of the key challenges for the organisation. Whilst there has been a significant reduction in absence levels over the past 18 months, rates remain higher than desired and therefore a continued focus on supporting good attendance at work is needed by both managers and the People and Culture team. Increased pressures on our people like handover delay, missed breaks and cost of living impact on health and wellbeing. The Health and Wellbeing Plan 2025-2029 and People and Culture Plan 2023-2026 provide strategic direction for relevant initiatives.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Significant policy frameworks and strategies embedded across the organisation including Managing Attendance at Work Policy, R&R, Speaking Up and the Health and Wellbeing Plan in place and followed with support from the P&C team.	1. (a) Audits undertaken by People Services Team (b) Outputs reviewed (c) Process reviews (d) PS team engagement on additional activities which could be delivered (e) Case support, advice and guidance with action planning to reduce absence R&Rs addressed in timely way to reduce risks of sickness absence. Compassionate Practices approach engaged. Referral of colleagues to appropriate levels of support Policy reviews to ensure policies and procedures are fit for purpose in line with agreed time frames Completed - 28/11/23 Speak Up Safely process introduced from the start of October 2023 including the appointment of one Trust guardian. The Health and Wellbeing Plan 2025-2029 and People and Culture Plan 2023-2026 provide strategic direction for initiatives to improve the workplace, in line with HEIW Best Practice Guide for Organisations. These documents support us in ensuring that our offer is focused, and evidence driven.
2. Operational Workforce Recruitment Plans, roster reviews and implementation to actively address demand and capacity and ensure sufficient resources to meet workload pressure	2. Maintenance of the workforce establishment to seek to ensure that colleagues are not unnecessarily stretched through vacancies
3. Return to Work interviews are undertaken - SharePoint Sway document ensuring accurate reporting of reason for absence and identifying any additional support required	3. Process regularly reviewed and managers are trained and coached on the need to complete returns to work promptly
4. Training for managers on all aspects of Managing Attendance – ensures focus is high and understanding of why this is important is maintained	4. Managing Attendance training register of attendees.
5. Reporting to Board, CASC, PCC, ELT, SLT, SOT, Directors and managers on sickness data. Leadership reporting includes deep dives and analysis of data.	5. Appropriate reporting for assurance to a range of audiences with feedback and support for further action.
6. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme- providing professional support	6. Managers have access to specialist advice and guidance from People and Culture team colleagues
7. Suicide first aiders, TRIM, Peer Support Networks, coaching and mentoring framework in place giving additional layers of support, Health and Wellbeing Steering Group in place.	7. Reporting in place on numbers of suicide first aiders and demand for support. Reporting on access to TRIM **and Wellbeing Service, including reporting themes and user experience feedback** Promotion of wellbeing support across WAST.
8. Staff surveys- assess levels of engagement and wellbeing	8. Use of HIVE survey tool and insight data from the NHS Wales staff survey provides feedback on overall engagement and wellbeing
9. Stress risk assessments- identify measures that can be taken to address issues	9. Reference to the assessments during attendance management line manager training and to the use of stress risk assessments promoted to managers
10. External agencies support e.g., St John Ambulance, Fire and Rescue- if needed at times of increased demand pressure	10. SLA Agreements.

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:	11/04/2025	TREND	20 (5x4)
		Date of Next Review:	11/05/2025	➡	

IF	THEN	RESULTING IN
there are high levels of absence e.g., sickness and alternative duties.	there is a risk that there is reduced resource capacity	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

11. Guidance for managers on alternative duties and monthly reviews of colleagues on Alternative duties	11. Action planning and timeboxed activities to support in a timely way.
12. Sickness audits for localities- provides additional level of detail and additional support for areas with higher sickness levels to support work to reduce those levels	12. Delivery of audits and follow up actions
13. Review of top 100 cases -carried out monthly	13. Provides a focus on higher risk cases where more intense action or support may be required.
14. Delivery of specific projects and pieces of work to support the reduction of sickness absence across the organisation.	14. Offers assurance to ELT on the activities and measures in place. Figures on absence are being reported monthly to ELT which is reflected in the minutes and AAA reports
15. Work in Confidence system implemented and Guardian appointed to support colleagues coming forward with concerns and potentially reducing levels of stress and avoiding sickness absence.	15. External Management (2nd Line of Assurance) and Audit.
16. Strengthen Speaking Up Safely Arrangements policy and advice and roll out of increased awareness of routes to speak up and raising concerns.	16. Monitor SUS concerns and they are dealt with in agreed timeframes and assessed whether absence related to mental health and anxiety reduces.
17. Actions identified from the Managing Attendance Audit implemented	17. Agendas, minutes etc.
18. PADR review undertaken and now including wellness questions	18. Underway and now BAU – ensures managers are talking about individuals' wellbeing and what additional support or signposting can be provided
19. Specific interventions on all long-term sickness absence cases to ensure there is a tailored, individual action plan which identifies interventions that will support a return to work as soon as reasonably possible.	19. PADRs undertaken and questions asked; Discussion on levels of long-term sick absence is undertaken in a variety of forums including JCC, ELT and PCC.
20. Accountability meetings on attendance management between People Services and senior ops managers to ensure this issue is given sufficient focus on priorities and ADs hold their senior teams accountable for their team figures	20. Meetings taking place and active on operational areas experiencing high levels of absence
21. TU engagement on attendance issues e.g. muscular skeletal conditions is discussed regularly at the H&S Committee and relevant additional interventions are identified	21. Included on agendas and outcomes are available for discussion at H&SC.
22. Review of top 100 cases by the wider People & Culture Team - monthly (Wellbeing, OCC Health, People Services). This takes place to consider whether any of those cases required additional interventions.	22. Director of People receives assurance from the team following each of the monthly meetings.
23. **Supporting managers handling attendance issues with skills, capability and confidence**	23.
24. **Coaching for managers on a case-by-case and locality basis.**	24.
25. **Enhancing manager awareness of attendance options like flexible or reduced hours. Ongoing efforts focus on managers approving and finding mutually agreeable solutions with requesters.**	25.
	Independent Assurance (3rd Line of Assurance)
	1b. Internal Audits scheduled through Shared Services Partnership. Last audit on attendance was November 2022 and the last actions from this due at the end of December 2023. (last audit November)
	2. **Internal audit of Occupational Health and Wellbeing completed with reasonable assurance, completed March 2025**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
(a) Consistency and Application in Managing Attendance at Work Policy	There are other factors that impact on sickness which are difficult to control as they are linked to system wide challenges
	Absence data is not updated in a timely manner into ESR by managers
Opportunities to improve education and communication with managers about resources available and how to implement it e.g., stress risk assessments	Further roll out and access to learning around sickness absence on process, supporting docs and on how to approach managing attendance

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Develop guidance and training for line managers to equip them with the confidence and skills to have meaningful and sensitive conversations related to attendance.	Head of Culture	31/05/25	Measured through ongoing participation in development sessions and feedback from TU regarding management

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:	11/04/2025	TREND	20 (5x4)
		Date of Next Review:	11/05/2025	➡	

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

			handling of absence cases. Piloting bite size chunks in Autumn with results in January 2025. This will form part of Management Essentials being launched in quarter one.
2. Areas of business where attendance management has improved significantly to share learning across WAST	AD for Culture, Inclusion and Wellbeing	31/06/25	Staff story at PCC in 2024 and visit to another area with low absence in 2024.
3. Connect to other Ambulance sector organisations to identify additional interventions they have implemented to address attendance management, share learning and consider whether to adopt in WAST	Deputy Director, People and Culture	31/06/25	Discuss at PCC Business Meeting and share at ELT/PCC with recommendations. Looked at London Team Based Working model, given that LAS have attributed TBW to improvement in attendance rates.
4. Targeted culture change reviews are undertaken in areas of the business where levels of absence are high and other metrics such as turnover indicates concerns. Alongside this these areas are also experiencing significant change.	Director of Culture Change	Ongoing	Culture review action plans are produced and taken forward. Sick absence in these areas is evaluated and monitored to assess whether reductions are achieved.
5. Implementation of new approach to regularly checking in with staff. Piloting a simple conversation framework for Managers to use with their staff on a monthly basis which provides a focus on wellbeing, goals and personal development.	AD for Culture, Inclusion & Wellbeing	**Start of Roll Out May 2025**	Proposed Evaluation of pilot in EMSC after 6 months to assess if there has been a reduction in sick absence in specific areas where this approach has been adopted following culture work with teams. **1 April 2025 Managers Essentials due to begin May 2025.**
6. Development of the 2024/25 Managing Attendance Plan (see below for individual actions.	Deputy Director of People	To commence 30/05/24	Key plan actions noted below
7. Increase manager support on data interpretation and analysis	Deputy Director of People	31.09.2025	
8. Culture work on creating the sense of team and peer responsibility / ownership	AD for Culture Inclusion and Wellbeing	31.09.2025	Incorporated in Our WAST Way – Leadership at all levels and the through the culture champions network, with focus on Our Best behaviours.
9. Analyse link between hot spots and the culture in these areas to address cultural issues	AD for Culture, Inclusion & Wellbeing	31.03.2025	111 and 999 sickness levels reviewed: link to repetitive roles, exposure to distressed patients. Additional management layers in CCC should start to show positive impact on attendance. Consideration to be given to whether change management approach being applied in these areas is having an impact
10. Identify opportunities to improve roles – flexibility, control, confidence	Deputy Director of People / ADs, Operations	31.09.2025	Work to be undertaken to review whether any correlation between approved flexible working requests and attendance rates
11. Opportunities to adapt the work environment. Link to Risk 224 and Risk 558 regarding the risk with the impact on WAST colleagues of overruns as well as patients.	Deputy Director of People ADs, Operations Directorate colleagues	31.03.2025	ELT discussion via WASPT regarding feedback from TUPs on operational overruns and shift patterns. **This group is now up and running with TUPs and managers in collaboration to identify opportunities to reduce overruns.**
12. Review workloads and hours of work undertaken by colleagues. Including colleagues not on GRS.	Deputy Director of People /ADs, Operations	31.03.2025 **31.12.25**	**Yet to start due to other key projects and task and finish groups underway**
13. Review patterns of absence	Deputy Director of People	31.03.2025	Increase in STS, respiratory, coughs, colds etc.; example of targeted interventions put in place in response to identified patterns (Integrated Care). Reported to ELT **and PCC** in Feb 25 on findings.
14. Development of a mental health referral pathway	AD for Culture, Inclusion and Wellbeing	31.03.2025 **1 April 2025 complete**	Scoping being carried out by Head of Workplace Wellbeing, links with existing provision and access to appropriate support and guidance for managers. **Wellbeing team now offer support to access local services and will engagement**

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:	11/04/2025	TREND	20 (5x4)
		Date of Next Review:	11/05/2025	➡	

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

			services as appropriate (e.., accessing support for suicide risk)
15. Develop the team around the person model / individual support network	Deputy Director of People and Culture	31.03.2025	**Closer working with P&C team and managers on supporting colleagues who are off. Case reviews undertaken where appropriate**
16. Increase lifestyle advice and guidance	AD for Culture, Inclusion and Wellbeing	31.03.2025 **30 November 2025**	Occupational Health and Wellbeing Team developing expertise in specific areas; calendars of events; health promotion. **1 April 2025 – Plans in place but team capacity means postponed.**
17. Undertake proactive testing to identify undiagnosed conditions	AD for Culture, Inclusion and Wellbeing	31.03.2025 **1 April 2025 complete**	Health checks ready to be rolled out as soon as capacity allows. **1 April 2025 Health Checks being launched at CEO roadshows**
18. Review reporting on OH	AD for Culture, Inclusion and Wellbeing	31.03.2025 **1 April 2025 complete**	**1 April 2025 recommendations from OHW audit to increase data collected to help inform OHW provision.**
19. Review opportunities on men's mental health e.g. support groups	AD for Culture, Inclusion and Wellbeing	31.03.2025 **1 April 2025 complete**	WAST voices ensure that proactive support for men's mental health, links with Men's Shed's, specific webinars and targeted campaigns and events.

Risk ID 201	A loss of stakeholder confidence that damages the Trust reputation	Date of Review:	22/04/2025	TREND	20 (4x5)
		Date of Next Review:	22/05/2025	➡	

IF	THEN	RESULTING IN
there is an inability of the Trust to deliver its core services because of system or organisational pressures	there will be a loss of stakeholder confidence in the Trust	a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, 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: 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 16, 25, 27

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

Risk Commentary Q4 2024/25

The risk remains at the current score of 20 and is expected to stay at this level for the next six months. While the long-term aim is to de-escalate it, this will be a function of a number of variables, many of which are contingent on improved performance, reduced patient harm and successful implementation of the new performance framework and model . There is currently a dichotomy in terms of improved reputation with stakeholders, including Welsh Government, while the level of patient harm and related coroners' activity and media coverage remains high, which has an impact on reputation more broadly. On this basis, it is anticipated that a deep dive will be undertaken by the end of September 2025, which will consider a reprofiling of the risk in its entirety and, contingent on that outcome, look at amending both the risk and the risk score, including the potential to split the risk into separate strands.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. CEO and DSP meeting with HB CEOs throughout Q4 to informally discuss strategic ambition	1. Feedback reported via ELT, CMT etc
2. Revised engagement framework delivery plan is now described as the programme engagement plan and continues to be updated and revised to reflect feedback from stakeholders and revised timelines for strategy engagement	2. Reported at CMT at each meeting on who has been engaged with and risks that are emerging etc
3. Challenging of media reports to ensure accuracy.	3. Programme of daily media engagement documented on digital system
4. Media liaison to ensure relationships developed with key media stakeholders	4. Programme of daily media engagement documented on digital system
5. Routine stakeholder and staff engagement and WAST Live.	5. Agendas, minutes, and documents of engagement events. Informal feedback via ELT and reported via Trust Board (CEO update)
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., ELT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs.
7. Annual deep dives on reputation have been undertaken 2024/25.	7. Was reported to Committees, documented in minutes, action logs and papers
8. Engagement of the Board on matters of reputation in development sessions. If required, escalation procedure for issues to the Board where circumstances dictate, following discussion at ELT	8. Minuted meetings, action logs and Board papers
9. Regular engagement with senior stakeholders e.g., Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders	9. Informal feedback reported via ELT and occasionally in formal correspondence (nature of discussion often precludes formal recording)
10. Monitoring external factors that may affect the Trust	10. ELT verbally updated on a regular basis with written notes if appropriate
11. Board oversight, scrutiny and challenge of performance, concerns, quality	11. Minuted meetings, action logs and Board papers
12. Internal Quality and Performance monitoring in the Trust and raising system issues	12. Data provided though reporting to Committee and Board for scrutiny and feedback.
13. Reputation audit launched on 09 April 2024 and ran until 01 May 2024.	13. High-level results presented at People and Culture Committee on 09 May and at Board Development on 27 June to assist the Trust to understand the impact of the reputation audit and to support our approach to stakeholder engagement.
14. Development of a Winter Media Plan	14. Monitored daily by the team and updated based on media coverage and public sentiment.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Managing the narrative of the media	1.
2. Strategic collaboration – further work needed to formalise opportunities – to think about how this translates into an action	2.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Roll out of Programme Engagement Plan	Director of Partnerships & Engagement	Q4 24/25 and continued	Roll out underway.
2. Board Development Session on political landscape	Director of Partnerships & Engagement	Q3-4 2025/26	To be finalised in the programme.

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:	11/04/2025	TREND	20 (4x5)
		Date of Next Review:	11/05/2025	➡	

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	4	5	20
Target	2	5	10

IMTP Deliverable Numbers: 1, 15, 19, 24

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

Risk Commentary

The risk has been fully reviewed in the cycle and the risk **score has not changed due to continued tension and poor relationship between UK and Russia, along with increased cyber-attacks against NHS organisations.** Whilst the Trust and wider NHS Wales organisations have in place several layers of technology to protect the Trust and its information systems, there is still a risk that users will be fooled by phishing emails which are becoming ever more sophisticated. To raise user awareness of cyber threats the Trust ICT department run regular phishing exercises as well as short security training packages, reporting the results and uptake through IGSG and into FPC. **Unfortunately following the most recent phishing exercise a high number of users were fooled and would have been fully compromised in a real attack.**

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 (**last approval 31/10/2023**). Incident Policy and Procedure put in place in February 2022 – **May 2024**
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 **August 2023** 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 **Assistant Director of Digital - 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**. Review of dormant account underway Q1/Q2 2025/26**
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. 04/08/23 – Exploring procurement of additional penetration tests with the aim of annual testing of all critical systems.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
15. Cyber/Info Security KPI are reported to senior management and committees	15. Monthly KPI reports now being generated routinely and fed into the Digital Leadership Group, ELT, IGSG and FPC
16. Regular cyber awareness campaigns are conducted	16. Cyber training is provided to staff and regular phishing campaigns are conducted. These are reported as part of the KPI reports
17 IT recovery Plan does include a cyber response	17. Cyber response incorporated into IT Disaster Recovery Plan

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:	11/04/2025	TREND	20 (4x5)
		Date of Next Review:	11/05/2025	➡	

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	4	5	20
Target	2	5	10

18. Information Security Policy refreshed and approved.	
19. Suite of business continuity exercises that departments can undertake to test their plans are available via EPRR.	19.
20. The cyber risk is reviewed and monitored	20. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources via ICT security team and reported to AD of Digital and DPO. 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.
21. SIRO in place and ISMS evolving in line with refresh of Trust information Security Policy	**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 **Next CRU external assurance review being undertaken 22 & 23 May 2025**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of understanding and compliance with policy and procedures by all staff members, continued education and awareness as per improvement plan.	1.
2. 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. Revised procurement guidance to be disseminated via ADLT.	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continued implementation and development of the Trust Cyber Improvement Plan	Senior ICT Security Specialist	Next checkpoint date 31.07.2025	Implementation of Cyber Improvement Plan actions ongoing and regularly reported into ICT SMT, DLG, IGSG and FPC.
2. Review of staff security guidance and awareness information	Senior ICT Security Specialist	Checkpoint date 30.06.2025	Given recent poor exercise results review content and delivery of staff information security results
3. Review of end user device security	ADoD - ICT	Checkpoint date 30.06.2025	**Review of current device security and potential improvement to strengthen without impacting on user experience**
4. Review of dormant user accounts	**Senior ICT Security Specialist**	Checkpoint date 30.06.2025	**Aim to reduce number of unused accounts**

Risk ID 641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Date of Review:	11/04/2025	TREND	20 (4x5)
		Date of Next Review:	11/05/2025	➡	

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

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

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Executive Director of Operations	**ASSURANCE COMMITTEE**	Finance & Performance Committee

Risk Commentary

Following the Manchester Arena Incident in May 2017, whereby twenty-two (22) innocent people were sadly killed, and the subsequent Public Inquiry (MAI), ambulance services across the UK have reviewed their ability to respond to a Major Incident. WAST has undertaken its own review and has identified sixty-eight (68) of the MAI recommendations as being pertinent to the ambulance service and/or multi-agency preparedness and response. Once these recommendations have been implemented then the risk will be mitigated to target; however, additional financial resources are required to do this.

As part of the Trust's ongoing commitment to deliver the necessary change against the MAI recommendations, a dedicated team was established in June 2023 to investigate and assure the Board that all necessary organisational processes were in place should an incident occur in Wales. Since the beginning of this project, significant progress has been made in addressing the recommendations (as identified in the 'Controls' section below) and the Trust is better prepared because of the work undertaken to date.

As part of the ongoing work, the Trust has completed a series of investigations and developed a series of 'Capability Reports' to demonstrate and explain where remaining challenges to an anticipated Major Incident could occur. The capability gaps identified are detailed in the below reports, which were shared with the Board, and are supported by a significant base of evidence produced as part of the 'R105' self-review process. The reports are:

- **R106 Capability Report**
- **Capability to Prepare**
- **Capability to Respond**
- **Capability of Specialist Assets**

The reports identify that a significant proportion of the MAI recommendations remain outstanding, and the Trust is unable to progress these further or fully implement the identified learning without financial support. The reports highlighted what is needed to complete or significantly progress twenty (20) MAI recommendations and forms the basis of the 'Gaps in Controls' and 'Actions' sections. Transitioning these gaps and actions across into the 'Controls' section when achieved will act as a longitudinal method of tracking progress of completion against the MAI recommendations, and the associated risk reduction as this occurs. If the Trust is unable to implement the MAI recommendations fully, there remains a risk to the public, the organisation, and commissioners in the event of a mass casualty incident.

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

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Forty-four (44) of the pertinent MAI Recommendations have been implemented into WAST practice through the work undertaken to date.	1. MAI recommendations that have been marked as implemented by the EPRR MAI Project are authorised and ratified by Operations Senior Leadership Team and cascaded via the approved governance route (AAA) to ELT and Trust Board. This forms a documented governance route for rationale for completion and details of this are recorded in the EPRR share drive alongside evidence of compliance. Additional details of assurance are provided in the annex to this Corporate Risk. Ongoing monitoring and assurance of lessons learned is captured through BAU processes and the established debriefing/lessons learned process such as the Organisational Learning Spreadsheet.

Risk ID 641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Date of Review:	11/04/2025	TREND	20 (4x5)
		Date of Next Review:	11/05/2025	➡	

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

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

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Four (4) outstanding MAI Recommendations, identified as pertinent to WAST by the self-assessment, require action against to implement the associated learning **(REF: MAI recommendations 1, 26, 88, 111).** These are not included in the R106 funding request.	1. Work is progressing against these recommendations as part of the ongoing MAI project. It is anticipated that these recommendations can be implemented without additional financial support. Regular updates on these four recommendations are provided through the regular 'touch point' meetings with EPRR HoS, ADO for National Operations & ED of Ops, with periodic updates to SLT that are then cascaded via the approved governance route.
2. Twenty (20) outstanding MAI Recommendations that have been submitted to Trust commissioners via the 'R106' process as requiring financial support to implement the learning **(REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 105, 106, 108, 109, 117, 124).**	2. The outstanding recommendations are not able to be implemented independently by WAST and may remain unresolved until such time that additional financial resources and practical arrangements are in place to support this work. Trust commissioners have been notified of this via the formal R106 submission completed in August 2024.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Implement the learning relating to forty-eight (48) recommendations identified in the MAI report as pertinent for WAST **(REF: Outstanding MAI recommendations 1, 26, 88, 111).**	Assistant Director of Operations, National Operations & Support	March 2025	This programme of work is underway, with nearly all recommendations completed. 4 recommendations remain outstanding, with a plan in place to implement all these recommendations.
2. Submit evidence to Commissioners demonstrating that additional funding is required to implement a further twenty (20) recommendations identified in the MAI report **(REF: MAI recommendation R106).**	Assistant Director of Operations, National Operations & Support	March 2025	**March 25- During March and April the Trust has engaged with commissioners on a series of scrutiny sessions to review content of submission for the MAI, following these scrutiny sessions it will be the commissioners to determine next steps and any subsequent course of action.** A formal submission of requirements has been submitted to commissioners for consideration and approval. Commissioners have been engaged with since early 2024 to raise awareness and facilitate early discussion. The Trust is awaiting a formal response to the submission.
3. Implement the necessary amendments to Trust infrastructure, resourcing level and equipment required to address the remaining recommendations once funding has been made available. (**REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 105, 106, 108, 109, 117, 124).**	Assistant Director of Operations, National Operations & Support	March 2029	An assortment of 20 proposals rests with commissioners at present. As these proposals are funded, capabilities gaps will be addressed and an associated reduction in the risk score can be expected. Some of these proposals may take several years to implement (e.g. a North Wales HART Unit) which is reflected in the target date. Other proposals could be accomplished in a much shorter timeframe if funded. Once the implementation of infrastructure, resourcing and equipment has occurred, WAST will either be compliant with the MAI recommendations, or, in some circumstances, may need to undertake further work to integrate the MAI learning into practice (e.g. once the EPRR Training & Exercising Team have established, they will then need to provide sufficient levels of exercising to comply with the exercising-related MAI recs).

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	11/04/2025	TREND	16 (4x4)
		Date of Next Review:	11/05/2025	➡	

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

IMTP Deliverable Numbers: 17, 18, 33

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

Risk Commentary
Challenges continue around resources and technology, and currently there is not an ability to reduce this score. Decarbonisation Programme Board continue to meet. Noting some progress on positive movement to actions within the DAP. Recent progress is focussing on implementation of PHEV and BEV SRVs.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Oversight of implementation and delivery of Decarbonisation project and monitoring of action plan at Decarbonisation Programme Board and Capital Management Board	1. Regular meetings of the Decarbonisation Programme Board quarterly. Requirements of the Decarbonisation project have been presented to the Trust Board & Finance and Performance Committee. Challenges of the project have also been highlighted. Report goes regularly to FPC and then onto Trust Board. **Next update will be May FPC meeting**
2. Capital and Estates directorate lead support – Director of Finance (DOF)	2. Regular briefings to DOF
3. Partnership working via Communications/Stakeholder liaison group with NHS Wales, Welsh Government and other bodies to gain support and knowledge- with the anticipation of working in collaboration.	3. Sharing of knowledge via partnership working through various forums is documented in minutes of meetings held. Requirements also form part of the action plan
4. Approach changed for heating/lighting/energy systems to become more energy efficient- replacing old inefficient plant with more sustainable technology such as natural gas boilers for air source heat pumps	4. (i) Estate Survey undertaken every 5 years. This is a 6-facet survey to understand where the back log is and the requirements for energy systems. **Next survey round to take place in 2025/26 which will inform the update of the Estates SOP.** (ii) Approved Estates SOP (iii) Estate Retrofit Guide and framework used to prepare schemes
5. Changing procurement practices for fleet, Estates, equipment, supplies, and ICT to reduce emissions	5. Fleet SOP shows move to ULEV vehicles. BJC 2024/25 details intention for move to EV for smaller and support vehicles
6. Board Development sessions with respect to Decarbonisation to raise awareness of decarbonisation requirements, additional sessions will be required.	6. Board Development session occurred on 8th November 2021 – presentation slides are available.
7. Finance & Performance Committee has oversight of decarbonisation project, decarbonisation to become a standard agenda item.	7. (i) Routine updates at every other FPC meeting (3 times a year) (ii) Annual report (which includes a Sustainability section) is approved by the Finance & Performance Committee
8. KPIs with respect to energy transmissions are communicated to Estates team annually by sustainability manager	8. KPIs to Estates team includes energy use at all WAST managed buildings
9. ISO14001 accreditation in place	9. ISO14001 – Annual audits are undertaken against the accreditation. Environmental Coordinators act as champions in the organisation.
10. Environment Strategy in place	10. Environment strategy has been approved by the Trust Board. This covers the next 5 years
11. Programme Board Risk Register	11. Programme Risk Register reviewed at every Decarbonisation Programme Board meeting
12. Reporting to WG via DCR reporting, qualitative, and quantitative reports and emissions reporting	12. Submissions to WG – quarterly DCR reporting. Annual qualitative and quantitative reporting
13. Membership of National Programme Board (WG), Transport Task and Finish Group and BELP Project Board	13. Minutes and papers of meeting
	External - Independent Assurance: • Sustainability section in Annual Report audited by Internal Audit. Annual audits by BSI on accreditation
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Establishment of further workstreams to address a Programme Plan to support strategy requirements	
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles	

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	11/04/2025	TREND	16 (4x4)
		Date of Next Review:	11/05/2025	➡	

IF there is a lack of resources and available technology and infrastructure	**THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	**RESULTING IN** negative environmental and social impacts causing reputational damage

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

3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited)
4. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Establishment of potential further workstreams to address a Programme Plan to support strategy requirements: Consider further workstreams required in support of delivering DAP actions, including grouping of similar actions	Capital Development and Estates Team	Not needed. Action closed.	Workstreams were set up to manage delivery of the EFAB projects and the transport element (Transport Project Board). Links are also made into ongoing work to develop the IMTP and develop longer term strategies e.g. Fleet Vehicle Procurement Strategy 2025 – 30.
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles: develop an investment strategy/prioritised list of sites where further EV charging is required. Will need further investment.	Decarbonisation Programme Board	March 2025 (in line with the IA recommendation action)	Actions taken in line with investment provided to implement rapid charging by end of March 2025 at a small number of sites. Confirmed adequate charging provision for the replacement of 20 x PHEV and 10 x BEV in March/April 2025. **This action is ongoing. Further consideration of the increasing resource requirements will be highlighted at the Transport Project Board, Decarbonisation Programme Board and through the Capital Management Board. Specific action in relation to development of investment plan was closed on the Audit Tracker in March 2025, given that this has been absorbed within other strategic investment plans.**
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited): development of specifications for vehicles considering achievable and safe ULEV options where possible. NOTE: will be dependent on confirmation of 2024/25 BJC funding	Fleet Team	March 2025	**Position remains that only vans can currently be purchased. This will be delivered by March/April 2025.**
4. NED support ended April 2022: A new NED will need to be nominated to champion this risk/project at Trust Board level	Director of Corporate Governance / Board Secretary	Not being progressed	To be further discussed with relevant Directors. It is unlikely that a NED Champion role will be allocated in the near future.
5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost: Development of an investment requirements schedule (also aligned to IA recommendations). Contribute resources to support the Decarbonisation Strategy action plan	Director of Finance & Corporate Resources	31.03.25	Discussions ongoing regarding enhanced resource requirements to implement low carbon emission vehicles. Targeted Estate Fund (TEF) bids being developed by 31st Jan 2025. **TEF bids were submitted, and it has been confirmed that 3 of the 6 submitted projects have been supported.**

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:	11/04/2025	TREND	15 (3x5)
		Date of Next Review:	11/05/2025		

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of a significant deterioration in staff health and wellbeing within WAST	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: 13, 14, 21, 26

EXECUTIVE OWNER	Director of People	ASSURANCE COMMITTEE	People & Culture Committee

Risk Commentary

This risk should be considered alongside Risk 160 as the resulting increased sickness levels mentioned above will be addressed by the same controls and assurances. The ongoing system pressures including long handover delays, overruns, missed breaks and the perpetuating impact of increased sickness levels continues to remain a challenge to mitigate this risk . WAST continues to work in partnership with the system to pilot viable options for addressing the external factors. Although there has been some success in some areas, we are yet to see these being scaled to an extent that the employee experience has been impacted. Since 2020 we have not seen the previous pattern of easing over the summer months and with the current public health risk of measles and continuing risks of covid this risk remains static. The People and Culture Plan 2023-2026 is a good summary of the controls and actions addressing this risk. Work on reducing shift overruns continues with various pilots being run to test viable options which could be implemented. Proposed increase in score as a result of system pressures. Whilst we are seeking to address this, and it will take time to have an impact. Adding in the potential future financial pressures (leaving vacant posts open for longer), will further exacerbate this issue

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
13. The new Health and Wellbeing Plan 2025-2029 has now been drafted and is out for consultation. The aim of the new plan is to expand on consideration of employee experience to recognise that individual wellbeing interventions are not sufficient in mitigating system wide pressures.	14. New Health and Wellbeing Plan 2025-2029 is aligned closely to People and Culture Plan and delivery monitored via the Health and Wellbeing Steering Group, reporting into the People and Culture Business Meetings. This plan was created in line with the HEIW Best Practice Guide for Organisations
14. Occupational Health & Wellbeing team with range of support options for individual mental health intervention signposting, MSK support, reasonable accommodations and recommendations, supported by mental and physical health expert clinicians.	15. Current waiting times are just above the national SLA of 29 days, at 31 days. , External providers meet quarterly and provide monthly engagement figures. Reporting into OHW operational team meeting and MIQPR.
15. Wellbeing Service providing training, consultation and advice to line managers supporting members of staff with severe and complex health and wellbeing challenges. Including REACT training that supports managers with difficult conversations.	16. Rolling programme of workshops, attendance at team events when requested, evaluation and numbers trained reported at OHW operational meetings. Diarised meetings, webinars and workshops in place through a rolling programme. These offers are now evaluated via user experience questionnaires which are reported to the health and wellbeing steering group. Wellbeing training uptake numbers is reported into the OHW Operational Team Meetings.
16. TRiM (Trauma Risk Management Network) in place to support staff following exposure to potential traumatic events and materials. The approach of watchful waiting by a clinician or peer supporter means we can support those who have been exposed to such events and escalate to support if required.	17. TRiM is facilitated by the Wellbeing Service Assistant Psychologists supervised by a Clinical Psychologist to provide appropriate professional oversight. Numbers of referrals, assessments, follow-ups and further support needs are reported to the Health and Wellbeing Steering Group
17. Acting on results of staff surveys relating to staff experience, data triangulated with pulse surveys and other cultural metrics as detailed in the People and Culture Plan.	18. Each Directorate has developed their own action plan to address staff surveys. NHS staff survey high level results released 19/02/24 with directorate specific data released in April 2024. The survey was repeated in Autumn 2024, and we are awaiting the next set of results.
18. HSE stress risk assessments	19. Undertaken by managers and advice is provided on how to use them by Occupational Health and Health and Safety teams.
19. KPIs are reported fortnightly regarding Occupational Health and Wellbeing activity	20. Received at OHW operational team meeting and reported in MIQPR.
20. Wellbeing drop-in sessions for CCC and 111 staff	21. These sessions are now part of business as usual across services and a user experience form is collating more formal quantitative feedback for OHW operational team meetings. Data to date has been qualitative and the quantitative has been measured by engagement with the service. Themes of staff concerns are also collated by wellbeing staff attending WAST sites.
21. Fast track physiotherapy to address MSK issues.	22. Regular review meetings with physiotherapy provider and monthly monitoring information received at People and Culture Business meetings and MIQPR
22. Occupational Health team inclusion in sickness and absence meetings	23. Qualitative anecdotal feedback has been positive, and it has strengthened relationships with the OH team. More formal feedback mechanisms are in development in line with our overhaul of service feedback.
23. Stress risk assessments	24. These are part of the IOSH Managing Safely Training.

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:	11/04/2025	TREND	15 (3x5)
		Date of Next Review:	11/05/2025	➡	

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of a significant deterioration in staff health and wellbeing within WAST	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

External - Independent Assurance - Audit Wales – Taking Care of the Carers report in October 2021 – all actions complete

GAPS IN CONTROLS	GAPS IN ASSURANCE
11. Need to increase the education and communication with managers about stress risk assessments. Presentation developed and shared with people services. Delivery dates being agreed in conjunction with Health and Safety, along with a new policy. These discussions have restarted, and colleagues are directed to the stress risk assessment information and education sessions will be started in Q1 & Q2.	Lack of awareness about staff wellbeing services, this continues to be a challenge due to small team, non-wired colleagues and competing communication messages.
	Effects of elevated REAP status affecting the ability of staff to engage with staff health and wellbeing services. Important to recognise the consistent reports of the impact of culture on wellbeing. Attendance at all events by operational staff consistently low due to service pressures.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. People and Culture Plan 2023-2026 relevant Actions	Assistant Director for Inclusion, culture and wellbeing	Annual Plan **December 2026**	First year reviewed at People and Culture Committee May 2024 23/7/24 Final year review included in consultation process for new plan
2. Health and Wellbeing Plan 2025-2029	Assistant Director for Inclusion, Culture and Wellbeing	Approved by Board Q3 2024/25 **2025/2026**	Plan has been approved by Board. The delivery period begins 2025/2026. Promotion of the plan and key deliverables will commence then.

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	11/04/2025	TREND	15 (3x5)
		Date of Next Review:	11/05/2025	➡	

IF a major incident or mass casualty incident is declared	THEN there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	RESULTING IN catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004

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

IMTP Deliverable Numbers: 1, 5, 6, 7,14, 15, 24

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary Q1 2024/2025

The challenges across the unscheduled care system**.** Handover lost hours in **January were 27,213 and February 18,816.** There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital E.Ds. Several incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.

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

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

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

·50% of vehicles released within 10 minutes

· 75% of vehicles released within 20 minutes

· 100% of vehicles released within 30 minutes

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

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

March25 – following review at SLT, it has been agreed to maintain the score as it stands currently.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Immediate release protocol	1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report provided weekly to the DG for Health & Social Services. V1.3 has been reviewed, updated and released (August 2024).
2. Resource Escalation Action Plan (REAP)	2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with **v5.1** released in **January 2025**
3. Regional Escalation Protocol	3. Daily conference calls to agree RES levels in conjunction with Health Boards
4. Incident Response Plan	4. The Incident Response Plan has been ratified via EMT
5. Mutual Aid arrangement with NARU	5. AACE National Policy on mutual aid in place
6. Clinical Safety Plan	6. CSP adopted by EMT and operational; reviewed annually by SLT in December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU. **New version 3.3 released in December 2024.**
7. Operational Delivery Unit 24/7 cover	7. Shift reports from ODU & ODU Dashboard received by Exec, SOT, and On-Call Team at start/end of shift and cover review at weekly performance meeting
8. In hours and Out of hours command cover	8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan. Cover review at weekly performance meetings
9. Notification and Escalation Procedure	9. Published procedure in operation, reviewed 3 yearly by SLT
10. Continued escalation of risk to partners and stakeholders	10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasised at the face-to-face COO Peer Group meeting on 14 April 2023.

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	11/04/2025	TREND	15 (3x5)
		Date of Next Review:	11/05/2025	➡	

				Likelihood	Consequence	Score
IF a major incident or mass casualty incident is declared	**THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	**RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004	**Inherent**	4	5	20
			Current	3	5	15
			Target	2	5	10

	External Independent Assurance N/A
11. CEO letter to Health Boards dated 3 Jan 2023, and DOO letter to Chief Operating Officers dated 30 March 2023 to seek assurance on plans.	11. Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of improvement with no delays more than 2 hours. Programme of improvement underway in ABUHB commencing at 4-hour tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.
12. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration.	12. All Health Boards responded with assurance of plans except BCU.
13. Multi Agency Exercise to be arranged.	13. This exercise has taken place although Health Boards declined to incorporate vehicle release plans
14. Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.	14. WG have confirmed that they have written to HB EPRR leads. Health Board COOs approved the proposals for vehicle release as outlined.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.	The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.
	Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morriston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).

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

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	11/04/2025	TREND	15 (3x5)
		Date of Next Review:	11/05/2025	➡	

IF	THEN	RESULTING IN
a major incident or mass casualty incident is declared	there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004

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

1. Review of Manchester Arena Inquiry	Assistant Director of Operations	March 2025	This programme of work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios. The financial case associated with MAI is planned to be familiarised with ELT and JCC during Jan and Feb 2024, with the final outline case to ELT in March 2024. A revised timeline for the governance process for the final MAI reports has been agreed, commencing in May 2024 and finalising at Trust Board the end of July 2024. 01/10/2024 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust continues. The Trust has undertaken a detailed review of its provision as part of its obligation under recommendations 105 and 106 and has recently produced an evidence-based series of reports aimed at addressing the identified gaps. This has been supported further by the development of three Quality Impact Assessments that have been approved by the Clinical Quality Governance Group. The work identified 20 recommendations for which there is a financial dependency. The submission to commissioners of the Trust's reports relating to these recommendations has now occurred and the Trust awaits their considered response. The remaining recommendations continue to be progressed, and it is anticipated these will conclude within the next six months. To ensure the continued visibility of these report findings within the Trust, a corporate risk is being developed for inclusion in the Trust's risk register. This will enable the alignment of outstanding MAI recommendations with a clearly defined business-as-usual framework, ensuring proper governance of capability gaps while awaiting financial decisions from commissioners and the implementation of necessary changes. Jan 2025 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust, continues. We expect to complete all recommendations that do not rely on financial investment by the end of this financial year. To ensure the continued progression and completion of the recommendations with financial dependency (18 recommendations), a corporate risk has been developed for inclusion in the Trust's Corporate Risk Register and Board Assurance Framework. As the risk progresses through the internal governance route, culminating in final approval at Trust Board in January 2025, there is an alignment of the outstanding MAI recommendations with a clearly defined business-as-usual framework, which will support the governance of capability gaps whilst awaiting financial decisions from commissioners and the implementation of necessary changes. **Mar25 – Progress of MAI will now be reviewed within CRR 641. During March and April the Trust has engaged with commissioners on a series of scrutiny sessions to review content of submission for the MAI, following these scrutiny sessions it will be the commissioners to determine next steps and any subsequent course of action.**
2. Further correspondence to Welsh Government to seek assurance of testing plans following recent mass casualty exercise where Health Boards declined to incorporate vehicle release plans	Assistant Director of Operations	November 2024	**Immediate Release Protocol Developed and Released August 2024.**Correspondence with Welsh Government remains ongoing. 22/02/2024 - Risk 594 has also been referenced in the context of MAI presentation to Welsh Government (6th Feb 2024). Further follow up will be provided as MAI progresses. Welsh Government has been and will continue to be kept up to date on the developing case, as have the JCC.
3. Request from COO network to share Action cards related to risk	Executive Director of Operations	Q1	May24 – LB will follow up with COO network on the sharing of their action cards to WAST. March 24 – This risk was discussed at both JCC management and in the COO meeting.

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	11/04/2025	TREND	15 (3x5)
		Date of Next Review:	11/05/2025	➡	

IF	THEN	RESULTING IN
the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage

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

IMTP Deliverable Numbers: 1, 13, 14, 18, 19

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

Risk Commentary

The consequences of this risk depend on the worst-case scenario which crosses of a number Domains on the Risk Scoring Matrix e.g. Loss of, or access to mass clinical data, the reputational damage this would cause, subsequent high-level involvement of ICO, Regulatory Body and Government involvement the subsequent fall out, fines and reduction in the level of clinical care. The likelihood would be small NB Just like pandemics. However, there are lower consequences of failure of statutory compliance which would warrant a higher level of likelihood even daily but in this case like near misses they indicate the need for change/improvement to demonstrate managing the risks. Therefore, the consequences will always be 5 but improvements are needed to lower the risk, and should we demonstrate meeting Statutory Requirements even if a serious incident/event/failure arises evidence provided would reduce / mitigate against the consequences.

IIn March 2025 the Trust submitted a self-assessment under the Welsh IG Toolkit, and met or exceeded expectations in all areas, except for the Training & Awareness category (for which minimum expectations were not met. Measured on the 25/03/25, WAST had achieved 79% compliance against an 85% target for statutory IG training addition, the Confidentiality Advisory Group (CAG), an independent body advising the **UK's** Health Research Authority, **recently required** organisations across NHS Wales to demonstrate compliance with legislation via the IG Toolkit **, or risk** requests for using sensitive patient information for research purposes **being rejected–** further resulting in risk to WAST's academic partnerships and reputation, and strategic research endeavours.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. **Expertise:** Data Protection Expertise: 2 x FTE Data Protection and Compliance Managers (DPCM); 1 FTE Information Governance Officer, 4 x FTE in the Cyber Security team	Two new permanent Data Protection and Compliance Managers **have been in post** since November 2024, bringing capacity of this skillset up to 3 x FTE.
2. **Expertise:** Permanent Data Protection Officer	2. Temporary Data Protection Officer responsibilities held by Head of ICT up to December 2024. A full-time, permanent DPO has been recruited, and the position has been filled since December 2024.
3. **Documentation**: Data Protection and Information Governance Policies and Procedures (Incl. DPIAs and Cloud Assessments)	3. Procedure for auditing Welsh Clinical Portal usage (by WAST staff) updated (Jun24). Monthly Information Governance Steering Group which includes progress DPC, DSA and DPIA reviews (I) IG Training IG Toolkit (System for providing a level of assurance of compliance (I) Incident Reporting Accountability to ELT Development of reporting (dashboard) which supports IGSG, ELT and Finance & Performance Board Committee for scrutiny.
4. **Documentation**: Contracts and agreements: Data processing, Data Sharing and Employment & Consultancy	
5. **Ownership:** Register of information assets and data flows (outdated)	
6. **Awareness:** Staff training on updated training module (Apr 2023)	**6. Training compliance monitored monthly via IGSG (captured on ESR and LMS365)**
7. **Monitoring:** Incident Reporting and management (DATIX)	7. Summary statistics reported monthly via IGSG
8. Monitoring: NIIAS **(national intelligent integrated audit solution)** for auditing access to personal information **across systems such as CAD and ePCR**	

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	11/04/2025	TREND	15 (3x5)
		Date of Next Review:	11/05/2025	➡	

IF	THEN	RESULTING IN
IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	THEN the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	RESULTING IN unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage

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

9. **Awareness**: Digital Notices / comms Ongoing (see Siren & recent Lock-screen notices)	Regular publication of IG related comms: Lock screen image issued 04/24 in relation to WhatsApp and training. This will be refreshed in 06/24. Siren notice drafted for ELT 05/24. AI Guidance issued 01/25. Cyber & IG procurement guidance drafted for release.
10. **Collaboration:** Proactive engagement outbound (not inbound to team)	**10a. Regular comms issued across WAST in Q3 and Q4 of 2024/25, explaining the importance and encouraging uptake of IG Training – this included targeted messages to non-compliant individuals, and their line managers, and escalations to Executive level as required.** **10b. Requests made for IG representatives to sit on project boards of critical workstreams, helping improve understanding, and collaboration, reducing risk of non-compliant go-lives or deliverables.**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1.	1. **Expertise**: Even with increased capacity without engagement by managers and staff to meet their compliance requirements there will continue to be information reported to IGSG which will demonstrate low levels of assurance i.e. Reports on DPIA log, DSA log, Training Levels, IG Toolkit, and Implementation Plan
2. **Documentation: Resource capacity constraints to update, implement or monitor the controls; and lack of engagement by management and staff which either bypass the requirements, policies or procedures.**	2. **Documentation: Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase IT systems, hire document scanning companies, external data consultants and analytical firms and bypass WAST's controls for appropriate due diligence or legislative required controls in managing these risks.**
3. **Documentation: Personal identifiable information (PII) is being processed or shared with no data processing contracts (DPC) or data sharing agreements (DSA) when legally required; or incomplete DPC or DSA due to stalled engagement.**	3.
4. **Ownership: New data, or new data processes which have either bypassed the controls or there are no information asset owner and therefore doesn't get on to the asset register or the dataflow is not mapped and creates a weakness in assurance (See 3)**	4. **Ownership:** Data Protection and Compliance Risks not fully realised. IGSG have approved the establishment of a sub-group to manage activities related to Information Asset Register and Ownership, however, due to vacancies and limited capacity in the IG team, this action will not be able to be progressed until January-25.
5. **Awareness: Currently not meeting levels of IG staff training.**	5. **Awareness:** Some data errors in ESR reporting for IG mandatory training has been identified, requiring manual effort to calculate Trust- wide compliance percentages.
6. **Documentation & Awareness:** Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase non-compliant IT systems.	6.
7. **Awareness:** The Confidentiality Advisory Group (CAG) notified WAST (via DHCW) in June 24 that for organisations with a 23-24 IG Toolkit outcome of "standards not met", any CAG approvals for research & non-research requests are likely to be rejected unless the organisations' IG Toolkit Improvement Action Plan can be met and evidenced by Nov 24 (instead of the original target date for this plan of Mar 25)..	7**. Awareness**: The Confidentiality Advisory Group (CAG) required WAST to submit an IG Toolkit Improvement Action Plan (via DHCW) with adjusted timelines to show a path to a "minimum standards met" position by Nov 24. The Improvement Action Plan has been adjusted and shared, and internal stakeholders notified. This will be managed by ADLT and monitored via IGSG**.** The Improvement Plan Actions were met by the Nov 24 deadline, satisfying the requirements of the CAG **up to March 2025. However, with the IG Toolkit submission in March-25 this view may reset.**

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. **Expertise:** Recruitment of Data Protection and Compliance Manager(s)	Leanne Smith	Q2 2024/25	Two candidates expected in post November 2024. Action complete – 2 new DPCMs in post since November 2024. Now included in Controls.
2. **Expertise:** Seeking funding to recruit/upskill/resource DPO who will encourage engagement**.** Additional funding into Digital for 24/25 allowed a permanent DPO position to be created within the structure.	Jonny Sammut	Q3 2024/25	JD evaluated and translated. Awaiting approval by Recruitment Control Panel to commence recruitment. Expected Recruitment and in post Q4 24/25.

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	11/04/2025	TREND	15 (3x5)
		Date of Next Review:	11/05/2025	➡	

IF	THEN	RESULTING IN
the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage

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

			Action complete – permanent DPO in position since December 2024. Now included in Controls.
3. Ensure compliance with the appropriate IG level training across all Directorate and Departments a. Demonstrate a regular series of comms on IG and DP - complete b. Regular monitoring of training compliance through IGSG – evidence of ongoing c. Targeted training compliance reporting to line manager on individuals to ensure that 85% target is reached **by March 2025. - not achieved** d. BAU on Siren training notices and specific guidance or advice – **evidence of ongoing** e. **IG checklist to be complete for all projects, and DPIAs ahead of project design / development, and critically all go-lives to have IG approval**	Leanne Smith	Q4 2024/25 **Q2 2025/26**	**3a.** Lock screen issued 04/24 in relation to WhatsApp and training. This will be refreshed in 06/24. Siren notice drafted for ELT 05/24. AI guidance issued 01/25. Cyber & IG procurement guidance in development. Evidence that regular comms is being published, and so action complete, and assurances added to Controls. 3b. IG training compliance **required to meet** 85% target **.** An Action Plan for training has been created, and a training needs analysis being progressed with L&D team. **Paper to ADLT Jun24 seeking support for increased awareness & training compliance Direct contact to individuals who have been non-compliant for a significant period of time, with escalation through their line management structures as required.** **See Action 5 for more specific detail on achieving the target.** **3d.** Procedures, such as audit of Welsh Clinical Portal usage, has been updated.
4. Report on physical security to IGSG – working with fleet and estates team	Leanne Smith and Aled Williams	Q2 2024/25 **Q1 2025/26**	Reporting to IGSG and FPC. A risk has been drafted by members of IGSG**, and agreed,** but action plan **now** to be developed in collaboration with Fleet & Estates.
5. Assurance of "standards met" for all IG Toolkit requirements: gain support of all Directorates' leadership to complete the IG Toolkit Improvement Action Plan and ensure compliance for the 24-25 IG Toolkit submission	Leanne Smith	Nov24 for IG Toolkit Improvement Action Plan (with evidence to CAG) **- complete** March 2025 for 24/25 submission **complete** **March 2026 for 25/26 submission**	Paper to ADLT Jun24 seeking support for completion of the IG Toolkit improvement action plan. To ensure no impact to CAG approvals for WAST research, this improvement action plan must now be met and evidenced by Nov24. The improvement plan actions resulting from the "standards not met" results of the 23/24 IG Toolkit submission were met ahead of the Nov24 deadline to assure CAG, however, to meet the requirements of the 24/25 IG Toolkit submission, further improvement work **was** required before the Mar25 deadline. **All other improvement work was complete, and the submission of the IG Toolkit in March 2025 saw standards either met or exceeded in all categories except for Training & Awareness, where standards were not met due to the IG Training compliance being below the 85% target.**

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	14/04/2025	TREND	12 (3x4)
		Date of Next Review:	14/07/2025		

IF WAST fails to persuade JCC/Health Boards about WAST ambitions	**THEN** there is a risk of a delay or failure to receive funding and support	**RESULTING IN** a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

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

IMTP Deliverable Numbers: 7, 9, 11, 12, 14, 15, 20, 24, 25, 32

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

Risk Commentary

From the 01 April 2024 111, emergency ambulance and Ambulance Care are all commissioned by the Joint Commissioning Committee (JCC). This is viewed as a positive development by the Trust, supporting the development of an organisational ambition.

The ambition is appropriate levels of patient safety and good working conditions for our staff across the 111 pathway, emergency ambulance care pathway and Ambulance Care pathway. Clearly neither of these are currently being achieved in the emergency ambulance care pathway as evidenced by the long waits, shift overruns and volume of concerns and reportable incidents. The Trust is currently commissioned on the assumption of 6,000 hours of handover lost hours, with current levels at 27,000 (Jan-25). The JCC had an ambition to achieve 12,000 handover lost hours by the beginning of quarter four 2023/24, which has not been achieved, but even if it was achieved, it would still be double what the EMS rosters are predicated on. The Trust has almost recruited up to the modelled 153 CHARU FTEs and connected to this focus on CHARU productivity. CHARU UHP in **January** 2025 was **94**%, which is the highest it has achieved, and it is now seeking to close the remaining gap through the recruitment of fully qualified paramedics. **The Trust delivered on its ambition to switch on key aspects of its clinical model transformation programme in 2024/25, in particular, rapid clinical screening, which included the recruitment of 28 FTES to EMSC (clinical navigators) and increasing the APP establishment to APPs.** The 111-call abandonment rate has stabilised post 111 CAS go live, as the Trust has recovered it call handler staff in post to establishment. Ambulance Care performance is stable. **For 2025/26 the Trust's ambitions are set out its IMTP, with a particular focus on delivering further aspects of the clinical model transformation programme: the re-categorisation of 999 demand (purple, red and RCS0 etc), remote clinical care and further see & treat capability. The EA skills mix (no funding from JCC) and Manchester Area Inquiry (MIA) submission are also important considerations.**

The JCC is now becoming more established. Current areas of focus for the JCC (in relation to WAST) include: a scrutiny exercise on the Trust's MAI submission, consideration of the Future Vision for NEPTS, **the Emergency Ambulance Measures Review Task Group and Ambulance Patient Handover Improvement Implementation (APHID) Group. The** Trust has received the JCC commissioning intentions 25/26 for 111, 999 and NEPTS**, which are reflected in the Trust's IMTP**. These are broadly supportive of the Trust's ambitions, but the financial pressures within NHS Wales **means** that there's **limited financial** support of the Trust's ambitions.

CONTROLS	**ASSURANCES**
	Internal & External Management (1st Line of Assurance)
1. JCC/WAST Forward Plan for EMS and NEPTS in place and monitored at JCC meetings	1. Minutes of meetings and a standard agenda item
2. JCC and its 2 sub-committees established as a forum to discuss WAST's strategy (sub-committees currently under review as part of move into JCC).	2. Minutes of meetings and a standard agenda item
3. Weekly catch up between Interim Director of 111 & Ambulance Commissioning /CEO	3. Meetings are diarised every week
4. Collaboration between JCC and WAST on specific projects e.g.	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 (currently paused as part of move into JCC).~~	5. **Note: this meeting has stopped and needs to be restarted, probably in a slightly different form.**
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholder's fortnightly
7. Commissioning intentions.	7. In year progress reported each quarter to the relevant commissioning meeting and 24/25 commissioning intentions approved for 111 Wales and expected to be approved by Mar-24 JCC (approved).
8. Governance arrangements for 111 commissioning: 111 Board, 111 Commissioning Board + 111 DAG etc.	8. Minutes of meetings and a standard agenda item
	External Management (1st Line of Assurance)

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	14/04/2025	TREND	12 (3x4)
		Date of Next Review:	14/07/2025		

IF WAST fails to persuade JCC/Health Boards about WAST ambitions	**THEN** there is a risk of a delay or failure to receive funding and support	**RESULTING IN** a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

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

1. Plans go to every bi-monthly meeting
2. Meet bi-monthly and agendas, minutes and action logs available

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. JCC remit is wider than just ambulances and will reduce the agenda time dedicated to WAST's three patient pathways.	1. A shorter provider brief will go to the JCC with more detailed discussions taking place at its sub-committees.
2. Governance coordination between the JCC and WAST to be improved.	2. Identified need for a governance meeting between JCC and WAST to manage the overall commissioner/provider interface. Actioned, but has lapsed due to capacity and resourcing in NCCU team. This will be further reviewed as the JCC goes live in April-24 (period of transition likely to extend through Q1). This has lapsed at this time, but request to re-establish it sent to commissioners. **This meeting has now been restarted.**
3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	3. Ministerial direction on handover reduction with significant pressure being applied to health boards through the NHS Leadership Board and NHS Executive accountability arrangements. The Welsh Government target is no waits > one hour, which equates to 7,000 lost hours. **WG has now established an Ambulance Patient Handover Improvement Implementation (APHID) Group to take forward this ambition.**
4. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control)	4. Strategic demand and capacity review **completed and reported to Finance & Performance Committee. Whilst the Director of 111 & Ambulance Commissioning is sighted on the findings, it has not yet been formally reported to the JCC, in agreement with WAST.**

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence JCC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	As part of 25/26 budget setting process in Q4 this year (18/03/25 F&P Committee). **IMTP now with WG awaiting approval, timeframe dependent on WG.**	26.06.24 Funding for a 32 FTE APPs secured for 2024/25 and 23.2 FTEs into Integrated Care. 06/08/24 WAST briefing on evolved CRM and 2023 EMS Demand & Capacity Review to JCC Board Development session in Aug-24. 21/01/25 ELT has considered the draft commissioning intentions and responded to the Director of Commissioning. **14/04/25 Commissioning intentions built into the Trust's 2025-28 IMTP with FTE additionality planned in the remote care and see & treat space. MAI scrutiny exercise on-going. Skills Mix Task & Finish on-going, due to report into ELT end of April 2025, no funding from JCC expected.**
2. Agree and influence JCC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	IQPD 12/02/25 **The APHID is a WG led group, so timeframe is dependent on WG.**	26/04/24 This modelling has been further supplemented by modelling the Ministerial target of no handovers of more than one hour. 26/06/24 May-24 levels at 24,000, which is higher than 2023 and concerning as an indicator of the winter the Trust may expect. Trust moving at pace to evolve clinical response model, with Welsh Government full sighted on impact of handover hours on the Trust. 21/01/25 The Trust experienced 26,000 ambulance unit hours lost to hospital handover in December 2025, in line with its prediction, but significantly above the WG target of no waits over one hour, which equates to approximately 7,500 hours. **14/04/25 WG has now established an Ambulance Patient Handover Improvement Implementation (APHID) Group to take forward this ambition.**
3. Increased understanding of NEPTS by JCC	Executive Director of Strategy Planning and Performance	02/08/23 30/06/24 20/08/24 21/02/25 **Timeframe tbc, subject to current discussion with JCC.**	16/04/24 Workshop arranged for April 2024 (completed). 26/06/24 Workshop results reported to newly established Interim Ambulance Commissioning Committee. 06/08/24 The WAST briefing to the JCC Board Development session in Aug-24 includes coverage of five workstreams, one of which is Health Transport, which includes NEPTS and UCS. 21/01/25 Consideration of Future Vision for NEPTS at JCC meeting on 21/02/25. **14/04/25 On-going discussions with JCC on the Future Vision, in particular, next steps, with possible development of a service blueprint connected to the Vision.**

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	14/04/2025	TREND	12 (3x4)
		Date of Next Review:	14/07/2025		

IF WAST fails to persuade JCC/Health Boards about WAST ambitions	**THEN** there is a risk of a delay or failure to receive funding and support	**RESULTING IN** a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

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

4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	02/08/23 Checkpoint Date **Timeframe for establishing a replacement for CASC Assurance is a JCC responsibility.**	30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue. 02.05.23 These have lapsed due to pressures and sickness absence in the NCCU. HB to reboot, subject to ability of NCCU to undertake. 28.07.23 Availability remains a challenge, but there is regular informal dialogue between WAST and NCCU. 18.01.24 This specific meeting remains lapsed, but the Trust is currently meeting every two weeks with the NCCU on the development of the IMTP. As the Trust moves into the new JCC from 01 April 2024 there will be a further opportunity to address this control. 16/04/24 The new commissioning arrangements are in transition and still quite fluid at the moment. 26/06/24 Request to commissioners to re-establish this meeting. 06/08/24 Meeting now re-established. 21/01/25 Meeting continues to operate. **14/04/25 Meeting continues, but the monthly CASC Assurance meeting has lapsed and needs to be restarted. This is anticipated by the Trust but is dependent on the Director of 111 & Ambulance Commissioning discussion with JCC colleagues.**
5. Develop and roll out the Stakeholder Influencing Plan	Director of Partnerships & Engagement AD Planning & Transformation	Q2 24/25 onwards	15/03/24 This action is captured in Risk 201 on the CRR. The reputation audit being repeated in Q1 will inform the development and roll out of this plan in Q2. **14/04/25 The CMT Programme Engagement Plan (PEP) is live. During Q4 the programme has undertaken a series of priority engagement sessions with key clinical groups and stakeholders on the Clinical Services Model proposals. The next steps are to undertake wider system engagement**

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	11/04/2025	TREND	12 (4x3)
		Date of Next Review:	11/07/2025	➡	

				Likelihood	Consequence	Score
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	**Inherent**	5	3	15
			Current	4	3	12
			Target	4	3	12

IMTP Deliverable Numbers: 1, 13, 14, 19, 22, 30, 32

EXECUTIVE OWNER	Director of People	ASSURANCE COMMITTEE	People & Culture Committee

Risk Commentary

A tailored bespoke development programme for managers and Trade Union Partners at all levels has been launched to address issues. The programme of engagement and relationship building will continue throughout 2024/25. Also, specific workforce issues related to potential respect and resolution processes have been addressed.

Work is well underway to seek to improve partnership working through the delivery of the action plan. The engagement structures below WASPT are in place and running. The Deputy Director of People Services and Head of Culture and OD have delivered workshop sessions for TU partners and managers across the organisation in senior and local roles. Personal relationships with TUPs are generally good . At a local level there are ongoing discussions on a range of organisational change issues and currently engagement and partnership working is operating well and as a result the score has been reduced to 12 (3x4) during the quarter. However, there is a recognition that the nature of partnership working and the issues that arise mean that the level of risk fluctuates more regularly than others and will be kept under review. The Executive Owner will change from November 2024 to Director of People – same for Risk 160. It is noted that work required on financial sustainability to meet savings requirements and projects such as reviewing the skill mix has the potential to disrupt relationships and may lead to a review of the score. On a national level, TUPs have not accepted the 2025 pay offer of 2.8% and there is a risk for industrial action should the offer not be improved.

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 TUPs 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 because 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 are 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 TUPs and Senior Operations Team in place and operating	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
10. Structures below WASPT in place from June 2023	10. Triple A reports through to WASPT and to PCC. Any escalations are appropriately noted.
11. Project plan in place to support the improvement in relationships based on the ACAS report from 2022.	11. Development of mentoring and training opportunities for TUPs to support their roles**. Ongoing**
12. AAA report of formal Partnership Forum (WASPT) reported to PCC or Board in future (return to BAU).	12. Training for local managers and TUPs in development and diarised delivery for February / March 2024**. Complete**
13. AAA from SLT Partnership Forum and Corporate Partnership Forum reported to WASPT	13. Change in senior TU personnel on a temporary basis meaning new senior TU representative needs to be brought up to speed with work on improving partnership working.
14. 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.	14. Action plan developed and shared with TUPs. Implementation underway. A series of partnership working sessions (5) have been delivered to around 120 colleagues – managers and TU partners. Feedback from the sessions was captured and next steps were reviewed. There is an ACAS action plan which is a live doc and is reported to WASPT to update progress.
15. Rhythm of meetings to curate and focus on relationships	15. AAA, minutes, monthly sessions with CEO, DoPC and DoO. Informal sessions with CEO, DoPC and Branch Chair and Sec on a quarterly basis. 6 weekly meetings with DoPC on other partnership forum arrangements.

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	11/04/2025	TREND	12 (4x3)
		Date of Next Review:	11/07/2025	➡	

IF	THEN	RESULTING IN
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	there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	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

16. Increased mutual respect and TU partner understanding and appreciation of challenges and pressures facing the Trust	
17. **Rollout of partnership training across WAST**	
18. **Observation of partnership forums and development work on embedding partnership training is ongoing. Additional actions have been added to the action plan, and WASPT was updated on 27.01.25.**	
19. Consider how we celebrate success and capture the positive learning	Captured as part of social partnership conference and subsequent comms But BAU in terms of partnership approach
20. Delivery of Social Partnership Conference	Programme development underway.
21. Task and Finish group to be established to work on mitigating the impact of EAP Band 5 post introduction and wider skill mix discussions.	Email to TUPs from Director of Strategy and Planning. Meeting schedule in train. Meetings under way from the beginning of March 25. TOR in place, assessment criteria for options in draft, draft options collated. Fortnightly meetings in place
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. Refresh of engagement programme post Industrial Action and establish work	Deputy Director of People	**Q2 2025/6**	Plan agreed and being monitored via WASPT. The plan is dynamic with actions being completed and additional actions added to the plan as they arise. Draft training development underway in partnership with TUPs – list of training needs shared from TUPs. - Completed Principles on engagement being developed (in part from the training) and as a result the partnership statement will be updated. eLearning courses created by WG Social Partnership Team to be added to Learn365 Further session of partnership training to be scheduled in Q2 2025/6
2. Learning and Development opportunities for TU partners e.g. shadowing, digital skills, coaching and mentoring	Deputy Director of People	31/03/25 – Date and update to be finalised w/c 28/04	Captured in action plan. e.g. TU rep shadowing on cases
3. Develop consultation guidance for managers	Deputy Director of People	31/06/25	Date pushed out due to team capacity.
4. **Produce a report for ELT with a range of options on Skills Mix**	Director of People	31/05/25	

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	11/04/2025	TREND	8 (2x4)
		Date of Next Review:	11/07/2025	➡	

				Likelihood	Consequence	Score
IF the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the 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	**Inherent**	3	4	12
			Current	2	4	8
			Target	2	4	8

IMTP Deliverable Numbers: 9, 12, 15, 18, 24, 25, 30, 31, 32

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

Risk Commentary: Q4 2024/25 The risk has now been further reviewed in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to WG year to date to Month 11 of the 2024/25 Financial Year **and also the submitted draft Month 12 position of achieving a small year-end surplus.** The score is consistent with that of **Qtr. 3 2024/25** due to a presented opening balanced financial plan for 2024/25 and the Month **11 and draft Month 12** 2024/25 financial performance and positive savings delivery. It must be noted though that clear monitoring of a potential financial risk around workforce re-banding of EMT staff has been mitigated for 2024/25 financial year. **The Trust has submitted a balanced** financial plan for 2025/26 **as part of its IMTP return and will be continually monitored especially with the** current challenging financial climate for all public sector organisations that may also impact on WAST financial performance especially as the financial year progresses.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at FPC, and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	
3. Budget management meetings	3. Diarised dates for budget management meetings
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	
6. Monthly review of savings targets	6. ADLT monthly review
7. Regular review monitoring and challenge via WAST and **JCC** / CASC quality and delivery meeting with commissioners.	
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.	8. Diarised dates for ICMB meetings with regular monthly report
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications	9. Regular PSPP communications (Trust wide) on Siren
10. Forecasting of revenue and capital budgets	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, ELT, FPC prior to Trust Board for approval as appropriate according to value.
	External Assurances Management (1st Line of Assurance)
	5. Monthly Monitoring Returns to Welsh Government
	7. JCC management meetings. Monthly meetings with DAG for NEPTS.
	8. Bi-monthly Capital CRL meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering
	1-10 External audit reviews

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	11/04/2025	TREND	8 (2x4)
		Date of Next Review:	11/07/2025	➡	

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

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Lack of formalised service contracts between Commissioner and WAST as a commissioned body	1. None identified.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/24 31/03/25	In line with the recent WAST financial position and monthly monitoring letter sent to WG, WAST can resource the cost of the EMS staff itself. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/24 31/03/25	The Financial Sustainability Program (FSP) continues to be a key vehicle for the Trust to fully identify its savings program. Over delivery was achieved for the 23/24 financial year and the point of strong delivery is further highlighted with the programs ability to fully identify the 24/25 £6.4m savings plan before the start of the financial year.
3. Embed value-based healthcare working through the organisation	Executive Leadership Team and Value Based Healthcare Group	31/03/24 31/03/25	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.
4. Foundational economy, Decommissioning, and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/24 31/03/25	The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best value for money while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales. Ad hoc reports are received from Shared Services on WAST's progress in switching more expenditure to Welsh suppliers to keep the Welsh pound in Wales.

Key - List of Strategic and IMTP objectives

Strategic Objective 1: Providing the right care or advice, in the right place, every time		***BAF risks***
1.	A modern, easily accessible, user-friendly and integrated digital offer	223, 224, 623, 260, 201,163
2.	Rapid (111) call answering, initial triage and onward referral	223
3.	Timely, high quality clinical assessment, advice and referral	223, 224
4.	Seamless transfer of 111 callers to wide range of available pathways	223
5.	Immediate 999 call answering, and efficient and effective dispatch of the right resource	223
6.	High quality, timely, clinical triage, assessment and consultation, with personalised response	223
7.	High quality, immediate or timely on scene assessment, care and conveyance where needed	223, 100
8.	A range of 24/7 pathways available for further assessment or treatment, closer to home	223, 224
9.	A flexible, user-centred Non-Emergency Patient Transport Service with the right capacity in place to meet demand	100,139
10.	A dedicated and timely transfer & discharge service supporting HBs with their transformation agendas	223
11.	A clear vision for Ambulance care services that supports wider health and care transformation	100, 201
12.	A high quality, safe (NEPTS) service with improved patient experience	100, 139
Strategic Objective 2: Enabling our people to be the best they can be		
13.	Culture: • Enhance and strengthen internal capacity for delivering culture change • Develop amplify employee voice to increase employee engagement • Continue the implementation of our compassionate practices approach	160, 558, 623, 201, 163
14.	Capacity: • Implement our Strategic Workforce Plan • Continue to embed a culture of positive attendance management • Continue our focus on 'getting the basics right.'	100, 160, 163, 223, 224, 558, 594, 623
15.	Capability: • Grow and develop our leadership and management capability • Reinforce and promote career pathways and professional development. • Create an environment centred around effective, ongoing conversations ('Check Ins')	100, 139, 160, 223, 224, 260, 594
16.	Strengthen Welsh Language compliance through strong leadership, enabling Welsh language to flourish	201
Strategic Objective 3: Being at the forefront of innovation and technology		
17.	The right buildings in the right place, enabling our staff to provide the best and safest care across Wales	542
18.	The right fleet in the right place, enabling our staff to provide the best and safest care across Wales	139, 542, 623
19.	Develop & agree Digital Plan • Everyday essentials • Security, Safety & Cyber • Digital Pioneers • Transformation • Data, Information & Insight	163, 260, 623
Strategic Objective 4: Developing services in collaboration		
20.	Well-placed to influence system thinking / strategy development	100, 223
21.	Meet the requirements of the Wellbeing of Future Generations Act	558
22.	University Trust Status in collaboration with WG, embracing a 'democratised culture' of learning, research and innovation	160, 163, 223, 224
Strategic Objective 5: Being quality driven and clinically led		
23.	Systems that meet the requirements of the Duty of Quality and Duty of Candour	224
24.	Excellent clinical leadership	100, 139,160, 223, 224, 260, 594
25.	A culture of quality improvement with robust quality management systems	100, 139, 160, 201, 223, 224
26.	High quality Putting Things Right, Safeguarding and Health & Safety systems	160, 224, 558
27.	Meaningful engagement and co-production with communities	223, 224
28.	A risk management framework as a key enabler of our long-term strategy and decision making	No corporate/principal risks
29.	An integrated governance framework	No corporate/principal risks
Strategic Objective 6: Delivering exceptional value		
30.	Sustainable savings & efficiencies	139, 163, 224
31.	Generate income alongside our core commissioned functions	139, 224
32.	A Value-Based approach across the organisation which is embedded in culture	100, 139, 163
33.	Developing and implementing our plans for Environmental Sustainability and Adaptation	542