

Risk ID 223	The Trust’s inability to reach patients in the community causing patient harm and death	Date of Review:	08/07/2025	TREND ➡	OVERALL 25 (5x5)				
		Date of Next Review:	08/08/2025						
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	External (LxC)			Internal (LxC)			
			Inherent						
			Current						
			Target						

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

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

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

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

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

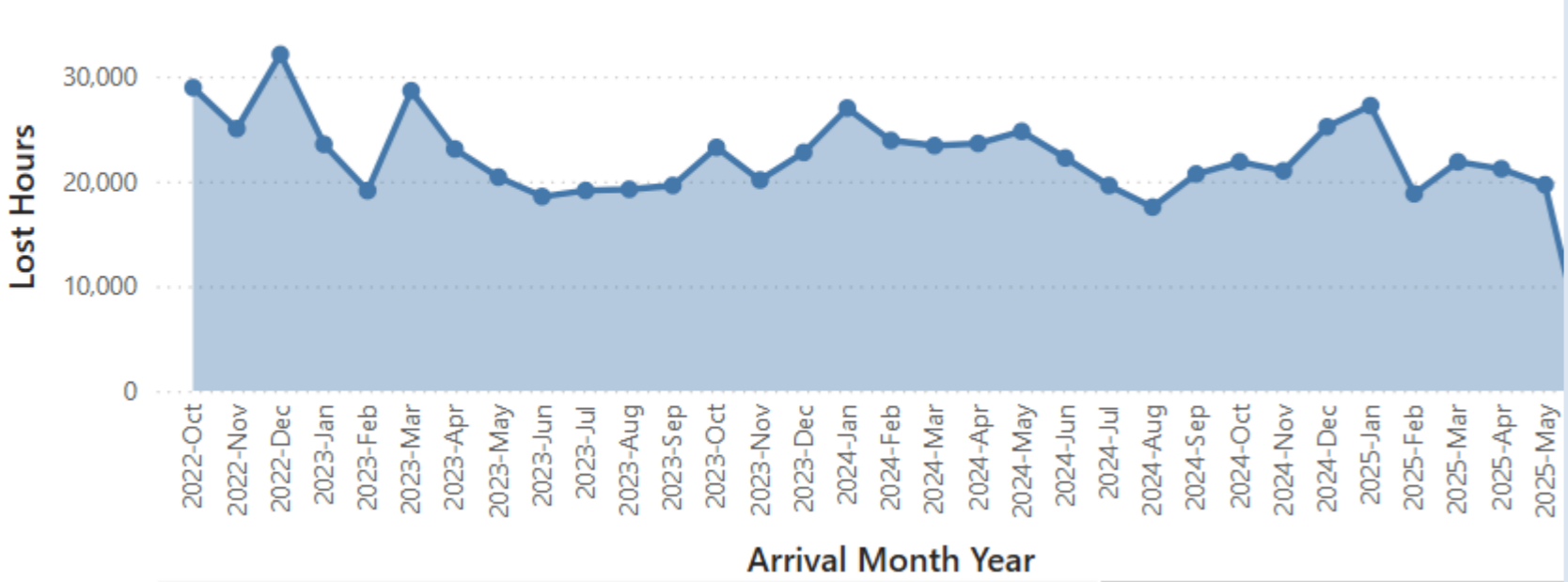
DRAFT Risk Appetite Level – Open

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

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

Risk Commentary

Lost Hours by Arrival Month Year



CONTROLS	ASSURANCES
-----------------	-------------------

MONITOR - External	External Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.
1. External Handover Improvement Group (NHS Exec)	1. Established handover improvement group led by the Director of Operations, NHS Exec to address persistent delays in ambulance handovers at Emergency Departments. The groups' purpose is to coordinate improvement plans across Health Boards, monitor compliance with national guidance and facilitate audits and performance tracking through NHS Exec oversight.
2. Welsh Health Circular	2. Setting national standards for 15-minute patient handover timeframe, clinical practice, quality governance and operational safety mandating actions like early warning score implementation and infection control whilst also embedding legal compliance through frameworks e.g Duty of Quality. Outcomes are primarily overseen by the Welsh Government through a combination of national audit

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/07/2025	TREND		OVERALL	25 (5x5)
		Date of Next Review:	08/08/2025				
		programmes and governance frameworks. The External Handover Improvement Group has been established consider the elements of the Welsh Health Circular.					
3. Local Delivery Units – Hywell Dda and BCU		3. A model to replicate oversight and scrutiny across Health Boards, like the Trust's Operational Delivery Unit (ODU). Activity will be based on the System Escalation Framework actions complemented by Local Action Plans – Date of implementation of LDUs to be confirmed					
4. Ministerial Advisory Group (MAG)		4. Providing independent oversight of NHS Wales performance and recommending standardise clinical pathways to reduce delays and improve outcomes. MAG promotes better use of data to monitor patient safety, while its recommendations are embedded into national risk frameworks and Board Assurance processes to ensure system-wide impact.					
5. Mitigating Avoidable Harm Actions		5. Actions were developed in direct response to persisting and escalating system pressures. The avoidable harm paper outlines a strategic framework to reduce patient risk with key measures including the clinical safety plan, Immediate release protocol and governance via the Serious Clinical Incident Forum (SCIF). Outcomes are monitored through risk scores, DATIX reporting, clinical audits and patient harm indicators. Actions were developed in direct response to persisting and escalating system pressures.					
MITIGATE - Internal How do we know the controls are effective. How will these impact the target risk score?		Internal over the three lines of assurance. How do we know the assurances are effective Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk					
Control 1 – Policies/SOPs Regional Escalation Protocol, Immediate Release Protocol v.1.3 (Released August 2024), Resource Escalation Action Plan (REAP – v5.1 released January 2025), Clinical Safety Plan (CSP – released December 2024).		First Line of Assurance Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly Performance, Demand and Capacity meetings to review REAP levels.		Second Line of Assurance ODU dashboards, Performance Demand and Capacity performance metrics data and DATIX and compliance reporting to the COO's.		Third Line of Assurance Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)	
Control 2 – Performance/Tactics ETA Scripting, CCC Emergency Rule, Red call performance, Transfer of Care, ARA (Swansea and YGC), EMS Demand and Capacity Review.		First Line of Assurance Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly Performance, Demand and Capacity meetings to review REAP levels. Local Business Meetings performance discussions.		Second Line of Assurance ETA dashboard, UHP reporting in local and business meetings. ODU dashboards, Performance Demand and Capacity performance metrics data, MIQPR (Monthly Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly).		Third Line of Assurance Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)	
Control 3 – Operational Activities National Risk Huddles, Performance, Demand and Capacity meetings, WAST Serious Clinical Incident Forum (SCIF), Operational Handover Group		First Line of Assurance Daily Risk Huddles, Weekly Performance Demand and Capacity Meetings, Local business meetings.		Second Line of Assurance Patient safety highlight reports. ODU Dashboards, Performance, Demand and Capacity performance metrics, MIQPR (Monthly Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly).		Third Line of Assurance Ministerial Advisory Group, NHS Exec Handover Group, Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)	
Control 4 – Resources 24/7 Operational Delivery Unit, Strategic, Tactical and Operational 24/7 system to manage escalation plans, APP (Advanced Paramedic Practitioner) deployment model, APP Navigation, CFR recruitment and deployment and CHARU implementation.		First Line of Assurance CSP review and escalation, On Call team start and end of shift, Performance, Demand and Capacity Meetings, Senior Leadership Team meetings.		Second Line of Assurance Shift reports, CSP review, On Call rota review, APP Dashboard, Volunteer performance highlight reporting.		Third Line of Assurance Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)	
Control 5 – Clinical Model Transformation (CMT) Consult and Close (including Mental Health Practitioners), Clinical review of code sets, Remote Clinical Support, Rapid Clinical Screening, expansion of See and Treat resources.		First Line of Assurance CPAS, DCR and CQGG Meetings, Clinical Model Transformation Project Board. Senior Leadership Team Meetings. Performance, Demand and Capacity Meetings.		Second Line of Assurance Performance, Demand and Capacity metric reporting, CPAS/DCR reporting, Volunteer highlight reporting, clinical model transformation highlight report.		Third Line of Assurance Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)	

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/07/2025	TREND	➡	OVERALL	25 (5x5)
		Date of Next Review:	08/08/2025				
GAPS IN CONTROLS		GAPS IN ASSURANCE					
External		External					
1. Inconsistent compliance with 15-minute handover standard by Health Boards which is inconsistent with the National standard set out by the Welsh Health Circular. Although national guidance exists, adherence is variable across sites and Health Boards, limiting WAST's ability to fully mitigate risk independently. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.		1. While Health Boards have developed handover improvement plans, there is currently no routine, structured mechanism for independent review or validation of their implementation, progress, or effectiveness. External Scrutiny is primarily limited to periodic updates through forums such as IQPD or JCC which may not provide consistent assurance of impact. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.					
2. Operational pressures within Emergency Departments and inpatient areas continue to affect the ability of Health Boards to consistently adhere to the 15-minute handover expectation, despite the presence of national guidance. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.		2. There is limited independent scrutiny or assurance regarding how capacity pressures within Emergency Departments and inpatient settings are being addressed by Health Boards. These constraints directly affect handover performance but fall outside of WASTs operational control or influence. Limiting the Trust's ability to mitigate the risk independently. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.					
3. Local Delivery Units limited to 2 Health Board Areas (Hywel Dda and BCU)		3. Inconsistency with the Local Delivery Units being implemented in only two Health Boards however recognising that the LDUs within Hywel Dda and BCU are in their infancy with potential rollout Pan Wales dependant on the success of the measurable outcomes.					
5. Inconsistent pathways across Health Boards		5.					
Internal		Internal					
1. Clinical Model Transformation (CMT) not fully implemented		1. Due to the implementation not being fully established there may be gaps in assurance meaning limited evidence currently or certainty that the controls are working as intended, however, as the model progresses the measurable outcomes will be reviewed and any concerns/issues addressed and monitored through actions. Current methods of monitoring the CMT includes CMT Project Board and an approved governance, reporting structure through T&F Groups.					
2.		2.					
3.		3.					
Actions to reduce risk score or address gaps in controls and assurances		Action Owner (Internal only)	Completion / Milestone date	Progress Update			
1. 6 weeks test of change Morriston		Sonia Thompson, Assistant Director of Operations		Jun 25 – Currently in week 6 with average handovers remaining under 50 minutes. WAST qualitative and quantitative data has been shared with Health Boards to continue the trial.			
2. Royal Glamorgan working to 45 minute handover		Sonia Thompson, Assistant Director of Operations		Jun 25 – Handovers with average of 30 mins. Current ongoing discussion to rollout trial in other areas.			
3. Clinical Model transformation (CMT) - 12 month pilot programme conducted to understand the full implications of the changes, identify issues and provide valuable insights into the effectiveness of the Clinical service model.		Pete Brown, Assistant Director of Operations, Integrated Care					
4. Cross reference the IMTP 2025-27 plan/deliverables with Corporate Risk 223		Judith Bryce, Assistant Director of Operations, National Ops and Support		Jun 25 – this is planned for the IMTP assurance meeting on 14 th July.			
5. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?		Chief Executive Officer		Jun 25 – Awaiting report from Audit Wales May 25 – Awaiting report from Audit Wales which will come through Audit Committee.			

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients			Date of Review:	16 July 2025	TREND	➡	OVERALL	25 (5x5)
				Date of Next Review:	16 August 2025	External (LxC)			Internal LxC
IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	THEN there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	RESULTING IN patients coming to significant harm and a poor patient experience	Inherent						
			Current						
			Target						
Strategic objective 1: Providing the right care or advice, in the right place, every time Work has continued to contribute to the design and development of a different approach to the Trust's highest scoring risks in a way that describes the internal and external controls, assurances and gaps which have been separated into those that the Trust manages and those that it monitors. The next steps will include testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death. Each of the assurances against the controls have been described over three lines of assurance. A future piece of work will be undertaken to score the effectiveness of these controls and assurances. The way the data is being presented in themes and categories supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level. This working draft is for discussion purposes and to highlight the direction of travel. There is still work to be done on this document.				DRAFT Risk Appetite Level – Open We are open to taking risks regarding changes to processes impacting the right care or advice. We understand that innovation and improvement may involve some risk, and we are prepared to embrace these opportunities to enhance our service delivery.					
EXECUTIVE OWNER		Executive Director of Quality and Nursing		ASSURANCE COMMITTEE		Quality, Patient Experience and Safety Committee			
This risk remains at the highest possible level, reflecting the enduring impact of significant ambulance handover delays at Emergency Departments on timely access to definitive care. The strategic implications for the Trust are considerable, with patient harm, deterioration, and poor experience continuing to generate regulatory scrutiny, including through Prevention of Future Deaths reports. The Trust has implemented a mature and embedded internal control environment, underpinned by real-time clinical and operational oversight through the Operational Delivery Unit (ODU), the Clinical Safety Plan (CSP), and system-level escalation mechanisms such as REAP and national risk huddles. These controls are further supported by structured assurance mechanisms including internal and external incident reporting, compliance monitoring, and governance review processes. Phase one of the Trust's Clinical Transformation Model - specifically the introduction of Code Changes for response - has now gone live, representing a key milestone in the delivery of an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. In parallel, early adoption of the <i>Wait 45</i> handover standard by some Health Boards represents a positive step toward reducing avoidable patient harm by supporting more timely transfers of care and improving the overall experience for patients awaiting treatment. While the Trust continues to demonstrate high levels of internal assurance, recent national focus on care standards and system performance provides a welcome opportunity to strengthen consistency and improve the effectiveness of wider system responses. Historic variation in adherence to national handover standards and the delivery of improvement plans has limited the extent to which the Trust can mitigate this risk through internal controls alone. However, increasing national scrutiny, greater transparency, and a shift toward more integrated, system-based accountability present a clear opportunity to improve consistency and collective impact across organisational boundaries. Strategic mitigation therefore remains focused on both internal transformation and system-wide influence. The Trust continues to engage proactively with national and regional programmes - including the Six Goals for Urgent and Emergency Care - to support shared learning, alignment of expectations, and strengthened collective ownership of outcomes. The pending Audit Wales report into the effectiveness of unscheduled care arrangements across NHS Wales will provide a critical external perspective on whole-system performance and may identify further levers to drive national consistency and accountability. Achieving the target risk score will ultimately rely on sustained partnership working, improved operational alignment across organisations, and the embedding of nationally agreed standards into routine delivery at every level of the system.									
CONTROLS					ASSURANCES				
MONITOR - External					External Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.				
1. Welsh Health Circular WHC/2024/041: NHS Wales Hospital Handover Guidance (15-minute standard)					1. Real-time ODU oversight and Clinical Safety Plan escalation where patients are delayed beyond 15 minutes, with clinical risk managed via NEWS triggers and local management actions.				

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	16 July 2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	16 August 2025		
National directive setting out compliance expectations for handover of care within 15 minutes. WAST operates in alignment with this standard, however the operational responsibility for implementation and compliance lies primarily with Health Boards. As such, this constitutes an external control which influences WAST risk exposure but sits outside the Trust's direct control.		Handover performance reported via IQPR and discussed through SLT and Quality Governance forums. Trends, outliers, and sustained delays are highlighted and tracked over time.			
2. Six Goals for Urgent and Emergency Care Programme Goal 4 <i>Rapid response in physical or mental health crisis</i> . The quality statement for this goal includes: Those arriving by ambulance at a hospital facility should be transferred safely from ambulance clinicians to the care of hospital clinicians in order of clinical priority and always in a timely manner (an hour at most).		2. Organisational performance is monitored externally through Six Goals Programme Board, Quality and Delivery Board, Integrated Quality, Planning & Delivery (IQPD) meetings, Joint Executive Team (JET) meetings, NHS Performance Board and managed within the NHS Wales Oversight and Escalation Framework.			
3. NHS Wales Performance Framework 2024-25 Measures 52 and 53 provide the expected performance targets in respect of ambulance handover timescales: 52. Number of ambulance patient handovers over one hour 53. Percentage of ambulance patient handovers within 15 minutes		3. Organisational performance is monitored externally through Quality and Delivery Board, Integrated Quality, Planning & Delivery (IQPD) meetings, Joint Executive Team (JET) meetings, NHS Performance Board and managed within the NHS Wales Oversight and Escalation Framework.			
4. NHS Wales Quality and Safety Framework and Duties of Quality and Candour The National Quality Management System (NQMS) brings together data from a number of sources, including patient safety incidents, for triangulation and to inform a range of activities in relation to learning and quality and governance assurance. The duty of quality in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ("the 2020 Act") has two aims - to improve the quality of services, and to improve outcomes for people in Wales. Together, the domains of quality and quality enablers create the health and care quality standards 2023.		4. Organisations provide statutory reporting against the Duties of Quality and Candour. National ED survey on Civica People Experience platform, results are monitored on a national Quality and Safety dashboard (Beacon)			
5. Nationally led operational escalation responses Risk Huddles, hospital escalation levels and daily national operational call					
MITIGATE - Internal How do we know the controls are effective. How will these impact the target risk score?		Internal over the three lines of defence. How do we know the assurances are effective Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk			
Control 1: Policies/SOPs/Resources Regional Escalation Protocol, Immediate Release Protocol v.1.3 (Released August 2024), Resource Escalation Action Plan (REAP – v5.1 released January 2025), Clinical Safety Plan (CSP – released December 2024). The CSP provides a structured, tiered framework for managing operational and clinical safety risks, including delayed handovers. It is supported by the 24/7 ODU, which ensures real-time oversight, escalation, and action planning. Together, they act as core controls to dynamically mitigate risk, coordinate escalation across the system, and support staff in delivering safe care under pressure. These are real-time, operational risk management controls that actively shape outcomes, especially in the face of delayed care environments. REAP outlines predefined escalation actions aligned to risk levels and is reviewed weekly by the SLT. National and local risk huddles enable shared situational awareness, trigger cross-system escalation, and ensure timely mitigation actions are documented and followed up.		First Line of Assurance (Operational) ODU shift reports, CSP real-time updates, REAP actions logged and enacted in real time; daily huddle notes and agreed actions monitored by Operational Delivery Unit	Second Line of Assurance (Internal Monitoring) Senior Leadership Team (SLT) weekly review of Resource Escalation Action Plan (REAP), Integrated Quality and Performance Report (IQPR)	Third Line of Assurance JCC and IQPD reporting. Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (<i>awaiting report from Audit Wales</i>)	
Control 2: Clinical Guidance for staff A Clinical Guidance document for WAST clinicians delayed outside the Emergency Department provides direction to WAST clinicians when asked to support care of a patient awaiting their care to be handed		First Line of Assurance (Operational) Datix incident reporting of any cases where clinical concerns are	Second Line of Assurance (Internal Monitoring) Oversight of incident management and learning through Ambulance Practice	Third Line of Assurance National reporting of high severity incidents.	

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	16 July 2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	16 August 2025		
<p>over to the hospital. The guidance ensures safe and appropriate clinical management within appropriate scopes of clinical practice.</p> <p>The Clinical Notice 07/2021 <i>Escalating a clinical concern with a deteriorating patient outside the Emergency Department</i> instructs staff to raise concerns with the Nurse in Charge of the Emergency Department and provides information on the internal escalation process through the DOM via EMSC, and then for senior clinical support via the on-call system. Clinical risk-triggered escalation using NEWS ≥ 5 for patients is reinforced via national clinical notices.</p>	<p>escalated. Incident management processes are followed in accordance with the Trust's Adverse Incident Policy.</p> <p>Compliance with mandatory training and competency standards</p>	Steering Group (APSG), Clinical Quality Governance Group and QuEST.	Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System <i>(awaiting report from Audit Wales)</i>		
<p>Control 3: Clinical Governance mechanisms</p> <p>Prompt and responsive learning from concerns (complaints and incidents) or from mortality reviews related to patient harm during delayed handover of their care should inform continuous system improvements.</p> <p>Incidents, complaints or medical examiner scrutiny referrals resulting in serious harm to a patient are reviewed at the Trust's Serious Case Incident Forum. Where harm may be attributed to delays in being able to handover their care at the Emergency department, cases are shared with the respective Health Board of patient residence to review the measures undertaken at the time of the delay to minimise risk and to identify opportunities to reduce harm in future. This is in line with <i>Section 4 Joint investigation process of the National Policy on Patient Safety Incident Reporting (May 2023)</i>.</p> <p>Learning from these incidents should be shared with the Trust once the Health Board has completed their investigation.</p>	<p>First Line of Assurance (Operational)</p> <p>Incident reports (Datix); regular meetings to capture learning medical examiner referrals; SCIF meeting records; immediate actions taken and documented in safety briefings</p>	<p>Second Line of Assurance (Internal Monitoring)</p> <p>Reporting to Clinical Quality Governance Group (CQGG); assurance papers to QuEST and other Board Committees</p>	<p>Third Line of Assurance</p> <p>NHS Wales Internal Audit, external reporting of severe harm incidents (Nationally Reportable Incidents).</p> <p>Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System <i>(awaiting report from Audit Wales)</i></p>		
<p>Control 4: Implementation of Duty of Quality, Candour & Quality Standards</p> <p>Internal governance structures, led by the Clinical Quality Governance Group and operationalised through the Quality Management Group (QMG), provide a structured approach to embedding statutory duties. These frameworks act as corporate controls to ensure care quality, transparency, and continuous improvement, particularly during periods of operational pressure such as delayed handovers.</p>	<p>First Line of Assurance (Operational)</p> <p>Compliance with statutory reporting duties – training and awareness uptake</p>	<p>Second Line of Assurance (Internal Monitoring)</p> <p>Monthly updates through Quality Management Group (QMG)? Monitoring via CQGG Quality dashboard under development</p>	<p>Third Line of Assurance</p> <p>Welsh Government assurance through Duty of Candour/Duty of Quality annual reporting.</p> <p>Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System <i>(awaiting report from Audit Wales)</i></p>		
<p>Control 5: Clinical Model Transformation (CMT)</p> <p>Consult and Close (including Mental Health Practitioners), Clinical review of code sets, Remote Clinical Support, Rapid Clinical Screening, expansion of See and Treat resources.</p>	<p>First Line of Assurance (Operational)</p> <p>CPAS, DCR and CQGG Meetings, Clinical Model Transformation Project Board. Senior Leadership Team Meetings. Performance, Demand and Capacity Meetings.</p>	<p>Second Line of Assurance (Internal Monitoring)</p> <p>Performance, Demand and Capacity metric reporting, CPAS/DCR reporting, Volunteer highlight reporting, clinical model transformation highlight report.</p>	<p>Third Line of Assurance</p> <p>Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System <i>(awaiting report from Audit Wales)</i></p>		
GAPS IN CONTROLS		GAPS IN ASSURANCE			
External		External			
1. Inconsistent compliance with 15-minute handover standard by Health Boards Although national guidance exists, adherence is variable across sites and Health Boards, limiting WAST's ability to fully mitigate risk independently.		1. While Health Boards have developed handover improvement plans, there is currently no routine, structured mechanism for independent review or validation of their implementation, progress, or effectiveness. External scrutiny is primarily limited to periodic updates through forums such as IQPD or JCC, which may not provide consistent assurance of impact.			
2. Operational pressures within Emergency Departments and inpatient areas continue to affect the ability of Health Boards to consistently adhere to the 15-minute handover expectation, despite the presence of national guidance.		2. There is limited independent scrutiny or assurance regarding how capacity pressures within Emergency Departments and inpatient settings are being addressed by Health Boards. These constraints directly affect handover performance but fall outside of WAST's operational control or influence, limiting the Trust's ability to mitigate the risk independently.			

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	16 July 2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	16 August 2025		
Internal	Internal				
1.	1. Routine clinical audit of patient management or deterioration during delayed handovers of care				
2.	2. Improved reporting on outcomes of joint investigations				
Actions to reduce risk score or address gaps in controls and assurances		Action Owner (Internal only)	Completion / Milestone date	Progress Update	
1. Contribution to the development of a national joint investigation learning repository		Assistant Director of PTR	Q1 2026	Pilot of the new module being undertaken with WAST and Cardiff and Vale UHB	
2. Clinical Model transformation (CMT) - 12-month pilot programme conducted to understand the full implications of the changes, identify issues and provide valuable insights into the effectiveness of the Clinical service model.		Assistant Director of Operations, Integrated Care	Q2 2026	01.07.2025 - Go Live implementation commenced 1 st July - phase one, code changes.	
3. Cross reference the IMTP 2025-27 plan/deliverables with Corporate Risk 224		Deputy Director of Nursing, QSPE	Q2 2025		
4. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?		Chief Executive Officer		May 25 – Awaiting report from Audit Wales which will come through Audit Committee.	

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:	02/06/2025	TREND	20 (5x4)
				Date of Next Review:	02/07/2025	➔	
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
IMTP Deliverable Numbers: 13, 14, 15, 22, 24, 25, 26							
Strategic Objective:							
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:	02/06/2025	TREND	20
		Date of Next Review:	02/07/2025		(5x4)
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.				
26. Wellbeing team have a referral pathway for mental ill health and are confident liaising with local services when necessary.	26. Regular reporting and the introduction of a user experience survey.				
27. Guidance and training available for line managers to equip them with the confidence and skills to have meaningful and sensitive conversations related to attendance.	27. Incorporated in Our WAST Way and measured through ongoing participation in development sessions				
28. 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.	28. Culture review action plans are produced and taken forward. Sick absence in these areas is evaluated and monitored to assess whether reductions are achieved.				
29. Culture work on creating the sense of team and peer responsibility / ownership	29. Incorporated in Our WAST Way – Leadership at all levels and through the culture champions network, with focus on Our Best behaviours.				
30. Health Diagnostic Programme available for those over 46 to identify undiagnosed conditions	30. Launched and staff trained. Clinics to commence end June 2025.				
31. Reporting on All Wales OH KPIs	31. Reporting in place, additional reports alongside the All Wales OH KPIs.				
32. Men's Health Support	32. Links available within siren and via the wellbeing practitioners to support mental health				
	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				

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:	02/06/2025	TREND	20
		Date of Next Review:	02/07/2025		(5x4)
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. 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.	
2. 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.	
3. 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 Management Essentials due to begin May 2025. 2 June 2025 Our WAST Way including Management Essentials launched on 28 May 2025.	
4. 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	
5. Increase manager support on data interpretation and analysis		Deputy Director of People	31.09.2025		
6. Analyse link between hot spots and the culture in these areas to address cultural issues		AD for Culture, Inclusion & Wellbeing	31.03.2025 revised date 31.12.2025	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. New date due to focus on launch of Our WAST Way by the team	
7. 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	
8. 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.	
9. 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	
10. 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.	
11. 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	
12. 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.	

Risk ID 201	A loss of stakeholder confidence that damages the Trust reputation		Date of Review:	28/05/2025	TREND	20 (4x5)
			Date of Next Review:	28/06/2025	➔	
IF there is an inability of the Trust to deliver its core services because of system or organisational pressures	THEN there will be a loss of stakeholder confidence in the Trust	RESULTING IN 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						
Strategic Objective:						
EXECUTIVE OWNER	Director of Partnerships and Engagement	ASSURANCE COMMITTEE	People and Culture Committee			
Risk Commentary Q1 2025/26						
This risk has been scored at 20 for some time, and has proven difficult to de-escalate, given performance challenges and the levels of harm experienced by some patients. It has become increasingly apparent that there are differential risks inherent in what is currently described as a single risk, e.g. the Trust's reputation with Welsh Government and commissioners is in a relatively stable position, but this is not necessarily the case with other stakeholders, nor with some patient groups where harm is most prevalent. On that basis, a deep dive review will be undertaken to determine how this risk could be reprofiled to provide a more accurate assessment of the reputational risk facing the organisation. This is likely to result in the disaggregation of the current risk, ensuring the risk definition and mitigation are appropriately differentiated and withstand scrutiny. At this stage, it is anticipated that the review will be completed by the end of Q2, with ADLT supporting the Director of Partnerships and Engagement in the deep dive process. Any amended risk(s) will be included in an updated Board Assurance Framework and will be reported through the usual governance routes.						
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 through 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 Q1 25/26 and continued		Roll out underway.	

Risk ID 201	A loss of stakeholder confidence that damages the Trust reputation			Date of Review:	28/05/2025	TREND	20 (4x5)
				Date of Next Review:	28/06/2025	➡	
2. Board Development Session on political landscape		Director of Partnerships & Engagement	Q3-4 2025/26	To be finalised in the programme.			

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:	08/07/2025	TREND	20 (4x5)
			Date of Next Review:	08/08/2025	→	
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:						
Strategic Objective:						
EXECUTIVE OWNER		Executive Director of Operations	ASSURANCE COMMITTEE		Finance & Performance Committee	
Risk Commentary						
<p>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.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> - R106 Capability Report - Capability to Prepare - Capability to Respond - Capability of Specialist Assets <p>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.</p> <p><i>This Board Assurance Framework (BAF) extract is supported by a more detailed appendix of itemised actions required to permit greater scrutiny of remaining gaps and actions, as well as a detailed repository of control measures that have been successfully implemented.</i></p>						
CONTROLS			ASSURANCES			
			Internal Management (1st Line of Assurance)			
1. Forty- eight (48) of the pertinent MAI Recommendations have been implemented into WAST practice through the work undertaken to date.			1. MAI recommendations that have been marked as implemented by the EPRR MAI Project are authorised and ratified by Operations Senior Leadership Team and cascaded via the approved governance route (AAA) to ELT and Trust Board. This forms a documented governance route for rationale for completion and details of this are recorded in the EPRR share drive alongside evidence of compliance. Additional details of assurance are provided in the annex to this Corporate Risk. Ongoing monitoring and assurance of lessons learned is captured through BAU processes and the established debriefing/lessons learned process such as the Organisational Learning Spreadsheet.			
GAPS IN CONTROLS			GAPS IN ASSURANCE			
1. Two (2) outstanding MAI Recommendations, identified as pertinent to WAST by the self-assessment, require action against to implement the associated learning (REF: MAI recommendations 26, 88). These are not included in the R106 funding request.			1. Work is progressing against these recommendations as part of the ongoing MAI project. It is anticipated that these recommendations can be implemented without additional financial support. Regular updates on these four recommendations are provided through the regular 'touch point' meetings with EPRR HoS, ADO for National Operations & ED of Ops, with periodic updates to SLT that are then cascaded via the approved governance route.			

Risk ID 641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Date of Review:	08/07/2025	TREND	20 (4x5)
		Date of Next Review:	08/08/2025	→	
2. Eighteen (18) outstanding MAI Recommendations that have been submitted to Trust commissioners via the 'R106' process as requiring financial support to implement the learning (REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 108, 109, 117, 124).		2. The outstanding recommendations are not able to be implemented independently by WAST and may remain unresolved until such time that additional financial resources and practical arrangements are in place to support this work. Trust commissioners have been notified of this via the formal R106 submission completed in August 2024.			
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	CLOSED	<p>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.</p> <p>May 25 – Progress report has been submitted to SLT and outstanding actions are now monitored through the risk register (Ref: 641). Submission to commissioners and further scrutiny sessions completed and awaiting commissioner outcome expected in August 2025.</p>	
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	CLOSED	<p>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 for the commissioners to formally respond to the Trust, determining next steps and any subsequent course of action.</p> <p>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.</p> <p>May 25 – Progress report has been submitted to SLT and outstanding actions are now monitored through the risk register (Ref: 641). Submission to commissioners completed and awaiting commissioner outcome expected August 2025.</p>	
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, 108, 109, 117, 124).		Assistant Director of Operations, National Operations & Support	March 2029	<p>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.</p> <p>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).</p>	

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan		Date of Review:	03/06/2025	TREND	16 (4x4)
			Date of Next Review:	03/07/2025	➡	
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						
Strategic Objective:						
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:			
			<ul style="list-style-type: none"> 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						

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	03/06/2025	TREND	16 (4x4)
		Date of Next Review:	03/07/2025	➡	
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles					
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited)					
4. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost.					
Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:		
1. 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 Ongoing programme of investment. Next phase to be complete by March 2026	Actions taken in line with investment provided to implement rapid charging by end of March 2025 at a small number of sites. Confirmed adequate charging provision for the replacement of 20 x PHEV and 10 x BEV in March/April 2025. This action is ongoing. Further consideration of the increasing resource requirements will be highlighted at the Transport Project Board, Decarbonisation Programme Board and through the Capital Management Board. Specific action in relation to development of investment plan was closed on the Audit Tracker in March 2025, given that this has been absorbed within other strategic investment plans.		
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 Ongoing programme of investment. Next phase to be completed by March 2026	Position remains that only vans can currently be purchased. This will be delivered by March/April 2025. Further PHEV SRVs and full BEV small NEPTS vehicles to be procured in 2025/26 for implementation by end March 2026.		
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 March 2026	Discussions ongoing regarding enhanced resource requirements to implement low carbon emission vehicles. Targeted Estate Fund (TEF) bids being developed by 31 st Jan 2025. TEF bids were submitted, and it has been confirmed that 3 of the 6 submitted projects have been supported. Work has commenced on the establishment of 2025/26 schemes.		

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:	05/062025	TREND	15 (3x5)
			Date of Next Review:	05/07/2025	➔	
IF significant internal and external system pressures continue	THEN there is a risk of a significant deterioration in staff health and wellbeing within WAST	RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	3	5	15
			Target	2	5	10
IMTP Deliverable Numbers: 13, 14, 21, 26						
Strategic Objective:						
EXECUTIVE OWNER		Director of People	ASSURANCE COMMITTEE		People & Culture Committee	
Risk Commentary						
<p>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 and missed breaks 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.</p>						
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.			13. 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.			14. 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.			15. 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.			16. 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.			17. 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			18. 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			19. Received at OHW operational team meeting and reported in MIQPR.			
20. Wellbeing drop-in sessions for CCC and 111 staff			20. 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.			21. 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			22. 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			23. These are part of the IOSH Managing Safely Training.			
			External - Independent Assurance - Audit Wales – Taking Care of the Carers report in October 2021 – all actions complete			

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:	05/062025	TREND	15 (3x5)
			Date of Next Review:	05/07/2025		
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. 2 June 2025 Plan being delivered and overseen by the Health and Wellbeing Steering Group which meets quarterly.		

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:	08/07/2025	TREND	15 (3x5)
				Date of Next Review:	08/08/2025		
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							
Strategic Objective:							
EXECUTIVE OWNER		Director of Operations	ASSURANCE COMMITTEE		Finance & Performance Committee		
Risk Commentary Q1 2024/2025							
<p>The challenges across the unscheduled care system. Handover lost hours in March were 21,855 and April were 21,193. 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.</p> <p>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:</p> <ul style="list-style-type: none"> · 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: <ul style="list-style-type: none"> · 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. <p>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.</p> <p>March 25 – following review at SLT, it has been agreed to maintain the score as it stands currently.</p>							
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 Dated 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:	08/07/2025	TREND	15 (3x5)
			Date of Next Review:	08/08/2025		
		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 11 th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morryston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).				
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:		
1. Review of Manchester Arena Inquiry		Assistant Director of Operations	CLOSED	This programme of work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios. The financial case associated with MAI is planned to be familiarised with ELT and JCC during Jan and Feb 2024, with the final outline case to ELT in March 2024. A revised timeline for the governance process for the final MAI reports has been agreed, commencing in May 2024 and finalising at Trust Board the end of July 2024. 01/10/2024 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust continues. The Trust has undertaken a detailed review of its provision as part of its obligation under recommendations 105 and 106 and has recently produced an evidence-based series of reports aimed at addressing the identified gaps. This has been supported further by the development of three Quality Impact Assessments that have been approved by the Clinical Quality Governance Group. The work identified 20 recommendations for which there is a financial dependency. The submission to commissioners of the Trust's reports relating to these recommendations has now occurred and the Trust awaits their considered response. The remaining recommendations continue to be progressed, and it is anticipated these will conclude within the next six months. To ensure the continued visibility of these report findings within the Trust, a corporate risk is being developed for inclusion in the Trust's risk register. This will enable the alignment of outstanding MAI recommendations with a clearly defined business-as-usual framework, ensuring proper governance of capability gaps while awaiting financial decisions from commissioners and the implementation of necessary changes.		

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:	08/07/2025	TREND	15 (3x5)
			Date of Next Review:	08/08/2025		
			<p>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.</p> <p>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.</p> <p>May 25 – Actions complete subject to closure report to SLT with outstanding actions monitored through the risk register (Ref: 641). Submission to commissioners completed and awaiting commissioner outcome expected August 2025.</p>			
2. Further correspondence to Welsh Government to seek assurance of testing plans following recent mass casualty exercise where Health Boards declined to incorporate vehicle release plans	Assistant Director of Operations	CLOSED	<p>Immediate Release Protocol Developed and Released August 2024. Correspondence with Welsh Government remains ongoing.</p> <p>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.</p> <p>May25 – Further correspondence submitted to the NHS Executive dated 28 April 2025, highlights that plans remain untested in the context of a continued deterioration on handover delays.</p>			
3. Request from COO network to share Action cards related to risk	Executive Director of Operations	Q1 CLOSED	<p>May24 – LB will follow up with COO network on the sharing of their action cards to WAST.</p> <p>March 24 – This risk was discussed at both JCC management and in the COO meeting.</p> <p>May25 – The Trust has now exhausted its influence on this risk, and with further correspondence to NHS Executive in April 2025 highlighting the outstanding risk and untested plans, the Trust considers all actions closed.</p>			


Risk ID 623	Failure to comply with Data Protection Legislation		Date of Review:	28/04/2025	TREND	15 (3x5)
			Date of Next Review:	28/05/2025		
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
IMTP Deliverable Numbers: 1, 13, 14, 18, 19						
Strategic Objective:						
EXECUTIVE OWNER	Director of Digital Services	ASSURANCE COMMITTEE	Finance & Performance Committee			
Risk Commentary						
<p>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.</p> <p>In 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 31/03/25, WAST had achieved 76.91% compliance against an 85% target for statutory IG training. In addition, the Confidentiality Advisory Group (CAG), an independent body advising the UK's Health Research Authority on the use of confidential patient information in research projects, and the Secretary of State for Health for non-research uses, recently required organisations across NHS Wales to demonstrate compliance with legislation via the IG Toolkit, or risk requests for using sensitive patient information being rejected – further resulting in risk to WAST's academic partnerships and reputation, strategic research endeavours, and patient data linkage initiatives should CAG support be pursued.</p> <p>If the Trust fails to meet the Minimum Expectations of the IG Toolkit, this highlights that the organisation may not be meeting its obligations under the accountability principle. The accountability principle places a responsibility on organisations to not only comply with the UK GDPR, but that they must also to be able to demonstrate compliance. If an organisation cannot show good data protection practices, it may leave them open to administrative fines (irrespective of a data breach), reputational damage and affect patients' trust in the organisation handling their data.</p>						
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			1. 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 updates on: - 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			4. Add: Template Model Data Processor Agreements and Data Sharing Agreements which are able to be produced when IG are engaged.			
5. Ownership: Register of information assets and data flows (outdated)			5.			

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	28/04/2025	TREND	15 (3x5)
		Date of Next Review:	28/05/2025		
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 and <u>MIQPR</u>				
8. Monitoring: NIIAS (national intelligent integrated audit solution) for auditing access to personal information on national systems such as WCP and WDS.	8.				
9. Awareness: Digital Notices / comms Ongoing (see Siren & recent Lock-screen notices)	9. Regular publication of IG related comms: Lock screen image issued 04/24 in relation to WhatsApp and training. _Lock screen image in relation to physical security as ongoing recurring screen. Digital Notice on Whatsapp issued 04/25. AI Guidance issued 01/25. Cyber & IG procurement guidance drafted and available on SharePoint and shared to ADLT. Information Governance Factsheet produced and shared to new users of WCP, WDS, and Secure File Share Portal (and as and when needed to other groups). Presentations on Data Breaches and DPIAs are provided to groups.				
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 and other Directorate forums , 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 engage third parties and/or 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 owners identified and therefore asset 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.					
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 will be reset, and WAST failed to meet the minimum expectations for Training and Awareness.				
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:	
1. 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	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. Ongoing comms on the importance of early engagement with IG to ensure legal required documents and risk assessment are completed will continue to be raised across forums.		

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:		28/04/2025	TREND	15
		Date of Next Review:		28/05/2025		(3x5)
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				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.		
2. 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.		
3. 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						
Strategic Objective:						
EXECUTIVE OWNER	Executive Director of Strategy, Planning & Performance		ASSURANCE COMMITTEE	Finance and Performance Committee		
Risk Commentary						
<p>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.</p> <p>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 its call handler staff in post to establishment. Ambulance Care performance is stable. For 2025/26 the Trust's ambitions are set out in 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.</p> <p>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.</p>						
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.			1. 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.			2. Minutes of meetings and a standard agenda item			
			External Management (1st Line of Assurance)			
			1. Plans go to every bi-monthly meeting			

Risk ID	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
		Date of Next Review:	14/07/2025		(3x4)
		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.	
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	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.	

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
			Date of Next Review:	14/07/2025		(3x4)
		Assurance is a JCC responsibility.	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:	03/06/2025	TREND	12 (4x3)
			Date of Next Review:	03/09/2025	➡	
IF the response to tensions and challenges in the relationships with TU partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained	THEN there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	RESULTING IN a negative impact on colleague experience and/or services to patients		Likelihood	Consequence	Score
			Inherent	5	3	15
			Current	4	3	12
			Target	4	3	12
IMTP Deliverable Numbers: 1, 13, 14, 19, 22, 30, 32						
Strategic Objective:						
EXECUTIVE OWNER		Director of People	ASSURANCE COMMITTEE		People & Culture Committee	
Risk Commentary A tailored bespoke development programme for managers and Trade Union Partners at all levels has been delivered with further training and activities to be developed for first line managers . The programme of engagement and relationship building will continue throughout 2025/26. Work continues on improving partnership working through the delivery of the action plan. The engagement structures below WASPT are in place and running. The Deputy Director of People and Head of Culture and OD have delivered workshop sessions for TU partners and managers across the organisation in senior and local roles. Personal relationships with TUPs are generally very good. At a local level there are ongoing discussions on a range of organisational change issues and currently engagement and partnership working is operating well and as a result the score has been reduced to 12 (3x4). 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. 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. Also, the departure of the CEO may cause some concerns amongst TU partners in terms of the risk of a change in approach to partnership working. On a national level, TUPs have not confirmed acceptance of the 2025 pay offer of 3.6% and there is a risk for industrial action.						
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.			3.			
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. TU partners in Task & Finish and Project Groups			6. Good attendance and commitment are observed at the meetings. TU partners listed as members in terms of reference			
			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.			
7. Local Partnership Forums, Corporate Partnership Forums and SLT/TUP and SOT/TUP well established and running and informal monthly meetings between TUPs and Senior Operations Team in place and operating			8. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings			
8. 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			
9.			10. Triple A reports through to WASPT and to PCC. Any escalations are appropriately noted.			
11. Ongoing project plan in place to support the improvement in relationships based on the ACAS report from 2022 updated and reported to WASPT			11. Development of mentoring and training opportunities for TUPs to support their roles.			
12. AAA report of formal Partnership Forum (WASPT) reported to PCC or Board in future (return to BAU).			12. Training for managers and TUPs delivered			
13. AAA from SLT Partnership Forum and Corporate Partnership Forum reported to WASPT			13. Stability in senior TU team			
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. Completed			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. Completed			

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	03/06/2025	TREND	12 (4x3)
		Date of Next Review:	03/09/2025	➔	
		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, DoP and DoO. Informal sessions with CEO, DoP and Branch Chair and Sec on a quarterly basis. 6 weekly meetings with DoP on other partnership forum arrangements.				
16. Increased mutual respect and TU partner understanding and appreciation of challenges and pressures facing the Trust					
17. Rollout of partnership training across WAST now to be extended to first line managers					
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 – completed					
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. Meetings completed business case in development for feedback to ELT				
22. Output from Conference informing next steps in developing maturity of relationship					
GAPS IN CONTROLS		GAPS IN ASSURANCE			
1. In maintenance and further improvement mode	None identified				
2.					
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 2025/26	Plan agreed and being monitored via WASPT. The plan is dynamic with actions being completed and additional actions added to the plan as they arise. Draft training development underway in partnership with TUPs – list of training needs shared from TUPs. - Completed Principles on engagement being developed (in part from the training) and as a result the partnership statement will be updated. eLearning courses created by WG Social Partnership Team to be added to Learn365 Further session of partnership training to be scheduled in Q2 2025/6 Development of learning events for first line managers including content in Our WAST Way		
2. Learning and Development opportunities for TU partners e.g. shadowing, digital skills, coaching and mentoring	Deputy Director of People	31/03/25 30.09 25	Awaiting refresh of the online learning by WG prior to publishing in WAST.		
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 30.06.25	Delay due to extended discussions with TUPs		

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:		30/05/2025	TREND	8 (2x4)		
		Date of Next Review:		30/08/2025				
IF the Trust does:		THEN there is a risk that	RESULTING IN		Likelihood	Consequence	Score	
<ul style="list-style-type: none"> 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 		the Trust will fail to achieve all its statutory financial obligations, and the requirements as set out within the Standing Financial Instructions (SFIs)	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								
Strategic Objective:								
EXECUTIVE OWNER		Executive Director of Finance and Corporate Resources	ASSURANCE COMMITTEE	Finance and Performance Committee				
Risk Commentary: Q1 2025/26 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 1 of the 2025/26 Financial Year. The score is consistent with that of Qtr. 4 2024/25 due to also presenting an opening balanced financial plan for 2025/26 and full allocation of the £8.5m savings delivery target. It must be noted though that clear monitoring of the savings target for 25/26 will be needed as this is £2m increase from the 24/25 delivered position and also 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, ELT, FPC and Trust Board in place				4. Diarised dates for ADLT, FPC and Trust Board and monthly reports with budget managers				
5. Welsh government reporting				5.				
6. Monthly review of savings targets				6. ADLT updated via core reporting. Reporting included in finance reports to committees and boards				
7. Regular review monitoring and challenge via WAST and JCC / CASC quality and delivery meeting with commissioners.								
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.				8. Diarised dates for ICMB meetings with regular monthly report				
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications				9. Regular PSPP communications (Trust wide) on Siren				
10. Forecasting of revenue and capital budgets				a) Monthly monitoring returns to ADLT, ELT 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 and at bi-monthly meeting with JCC Finance teams				
				8. Capital meetings with Trust and WG capital leads				
				9. Regular P2P meetings diarised (bi-monthly)				
				10. Monthly monitoring returns into Welsh Government				
				Independent Assurances (3rd Line of Assurance)				
				1-10 Internal audit reviews covering				
				1-10 External audit reviews				

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	30/05/2025	TREND	8 (2x4)
		Date of Next Review:	30/08/2025		
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	31/03/25 31/03/26	Supported financial plan included in IMTP for 25/26. At least bi-monthly meetings with WAST finance and JCC in relation to contract payments.	
2. Embed a transformative savings plan and ensure organisational buy in		Savings subgroup / FSP	31/03/245 31/03/26	The Financial Sustainability Program (FSP) will continue to be a key vehicle for the Trust to monitor and develop its savings program. Over delivery was achieved for the 24/25 financial year and the point of strong delivery is further highlighted with the programs ability to fully identify the 25/26 £8.5m 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	31/03/25 31/03/26	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	31/03/25 31/03/26	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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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